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LEGAL SERVICES FOR MENTAL HEALTH PATIENTS: A SELECTIVE REVIEW OF DEVELOPMENTS IN LEGAL AID/POVERTY LAW DELIVERY WITH PARTICULAR EMPHASIS ON COMMONWEALTH JURISDICTIONS

by

Robert Macaire Gordon

B.A. (Honours), La Trobe University, Melbourne, Australia 1979

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ABSTRACT

Analysis of recent developments in the mental health law and legal aid/poverty law movements indicates a fusion of interests. In those Commonwealth countries where legal services for mental health patients exist, a major impetus has been the establishment of general legal aid structures. These recent developments have also been influenced by legislation.

Although such developments have been to the advantage of patients, a number of problems have arisen. In particular, in reforming relevant legislation an attempt has been made to find a compromise between competing perceptions of patients' needs. In general, this area can be characterised as a conflict between lawyers, mental health professionals and patients as to the perceived mental health and legal needs of patients.

The extent to which a compromise is achieved affects the evolution of patients' legal services. In this respect, an examination of Canadian mental health legislation indicates that whilst some attempt has been made to find a compromise, in general, the perceptions of need held by mental health professionals have dominated.

As a consequence, legal services are at a stage in their evolution where they are obliged to maintain an adversarial approach towards the assertion of patients' interests. The evolutionary process in relation to all legal services seems to

involve an initial stage where needs are aggressively asserted, followed by the establishment of power by the client group, progressing to a less adversarial approach once equity is maintained. In this respect, the factor shared by all types of legal service is the assertion of power on behalf of disadvantaged clients. This involves placing clients on an equitable footing with the relevant agencies and professional groups.

The dysfunctional aspects of conflict between lawyers and psychiatrists will continue until the latter are prepared to assist in establishing equity of power in the doctor/patient relationship. Meanwhile, progress towards a more 'patient welfare' orientated approach to delivering legal services is blocked. Some treatment settings exist where patient power is acknowledged and lawyers and mental health professionals co-operate to the benefit of clients/patients. This fact tends to negate the view that co-existence is a utopian vision.

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Rob Gordon
Vancouver,
British Columbia: July 1981.

DEDICATION

TO ROMA, ROMA'S BROTHER
AND ROMA'S MOTHER: FORMER
CLIENTS OF A LEGAL SERVICE.

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I. INTRODUCTION

During the course of the last fifteen years major developments have been occurring, internationally, in the areas of mental health law and legal aid delivery. Whilst the two areas of activity have flourished in their own right, there has also been a marked fusion of interests. Those with a particular concern for pursuing and protecting the civil rights of mental health patients (both those defined as 'ill' and those defined as 'retarded') have often turned to legal aid facilities (in particular community legal services)[1] for support and assistance. Those involved with delivering legal services to the underprivileged in general have encountered mental health patients amongst their client group and, with the expansion of the concept of disadvantage, have extended their coverage to include, in particular, the institutionalised mentally ill.

Although this process has, in general, been well documented in the United States, the same cannot be said of Commonwealth jurisdictions. There is a noticeable lack of dialogue between legal service personnel specialising in mental health law matters across jurisdictions; as a consequence only a limited exchange of information occurs. There is a considerable knowledge vacuum even within the same country, a situation that is of questionable value in those places where such legal services have been established. In addition, a lack of information and dialogue hinders legal service personnel seeking to establish legal resources for patients in countries where the unmet legal needs of the latter are now being realised.[2]

As much of the material in this thesis has not been assembled and analysed before it will, hopefully, begin the process of improving relationships between existing legal services. In addition it will provide some information for those seeking to establish such services. However, the principal objective is more analytical. It will trace the fusion of the interests of the mental health law and legal aid movements from their inception; examine the current situation prevailing in Commonwealth jurisdictions; and offer a comment on future developments that may either emerge, or could be 'engineered'.

The thesis begins with an examination and discussion of developments in mental health law that have occurred in United States and Commonwealth jurisdictions. It is noted that considerable advances have been made in the pursuit of patients' rights in the United States although there is some indication that the process is now reaching a plateau. A feature of this latter development is a tendency for mental health professionals and mental health lawyers to seek out compromise rather than to continue in a context of confrontation. In Commonwealth jurisdictions, it is noted that mental health law is in a state of confusion. Whilst some effort has been made to assert patients' rights in a number of contexts, very few 'gains' have been made.

Following this, the discussion turns, in Chapter 3, to examine parallel developments that have been occurring in relation to the legal aid movement. The emergence of 'poverty law' as a specialist area of legal practice associated with legal aid delivery, is examined and the numerous difficulties that arose for this body of practice, especially in Commonwealth jurisdictions, are detailed. It is noted that as the concept of 'disadvantage' has broadened so those practising in legal aid/poverty law began to turn to address the unmet legal needs of numerous groups, including mental health patients (especially those classified as mentally ill). Indeed, it is argued that, especially in Commonwealth jurisdictions, the growth of legal aid systems can be seen as a major impetus for mental health law and for special legal services for mental health patients. In effect, a substantial fusion of interests has occurred.

This argument is supported by an examination of the evolution of legal services for patients in both the United States and the Commonwealth. It is noted that whilst many services exist in the former jurisdiction and legal aid systems/organisations have played an important role in developing such services, the sources of encouragement have been largely external to the legal aid movement. On the other hand, in three Commonwealth countries where patients' legal services exist (Canada, England, and Australia) inseparable ties exist between such services and legal aid systems. As such, it is argued that the evolution of patients' legal services is unavoidably affected by policies in relation to legal aid that exist in the various jurisdictions, as well as problems in relation to the practice of poverty law. A complete history of the development and a description of current legal services for patients in Canada, England and Australia is provided. The Canadian situation is examined in some detail.

In the course of examining this evolution it is noted that changes to mental health and other relevant legislation, in Commonwealth jurisdictions, may also have encouraged the growth of legal services for patients. Legal 'need' (notably in the context of civil rights) has been recognised and efforts made to provide patients with protections particularly in relation to involuntary commitment and continued detention. It is noted that in answering such need, further legal need is created; that is, the need for access to legal services which can give effect to the rights. However, it is argued that legislators have also tended to frustrate legal services by creating a confused and inconsistent situation in relation to those patients' rights that have been enshrined in legislation.

It is suggested that this has arisen because of a need to accommodate competing perceptions of the needs of mental health patients. Considerable conflict exists between such perceptions, the resolution of which may, it is argued, create a situation that will affect the continuing evolution of patients' legal services. In a dialectic sense, a synthesis will emerge from a current antithetical situation. It is suggested that conflict between competing perceptions of need is, currently, the major issue affecting legal services. Coming to understand this conflict will not only help in appreciating the current function, role and application of legal services, but also help to shape or 'engineer' future developments. As such, the thesis concentrates on this particular aspect of the evolution of legal services for patients. Although the impact of policies in relation to legal aid systems is equally important, the impact of legislation tends to highlight the central problem more clearly.

Therefore, Chapter 4 consists of an examination of the competing perceptions of patients' needs held by lawyers, mental health professionals and patients/patients' organisations. It is noted that the difficulty of determining 'need' is an issue common to both the legal aid and mental health movements. As such, the fusion of both movements has created a complex problem. The major contradiction between the health needs and legal (notably civil rights) needs of patients is examined. In this context, the use of the problematic concept of 'best interests' is also considered. The different perceptions of patients' needs are discussed and it is suggested that 'conventional' legal needs, as encountered in the wider, poverty law context, are of importance. Answering such needs can have benefits in the therapeutic context. It is argued that, despite the apparent conflict between perceptions of need, considerable agreement actually seems to exist. The possibility of internecine warfare between professional groups is canvassed in the light of the possibility that a 'common' enemy may exist in the form of governments who fail to allocate sufficient funds to mental health systems. In addition, it is suggested that where disagreement does exist, a main problem lies in allocating 'power' to patients; that is, treating them as other than 'incompetent' children.

Given that legislators have attempted to accommodate competing perceptions of need, and given that mental health and related legislation is a central factor in determining the work of legal services, the thesis then turns to examine relevant Canadian legislation to determine whether a compromise has been achieved. Chapter 5 offers a discussion and examination of the legislation in relation to mental health review tribunals and a commentary on the little that is known about the practical operations of such tribunals. The Chapter concludes with the argument that the relevant legislation demonstrates a preference for psychiatric-centred perceptions of patients' needs. This situation is compounded by the possibility that in practice such tribunals are dominated by psychiatrists and their attendant perceptions of need.

The thesis then turns, in Chapter 6, to an examination of four other areas in Canadian legislation where competing perceptions of need are apparent. It begins with an examination of the right to treatment and the right to refuse treatment. This is followed by a discussion and analysis of the problems of competency and capacity. The right to be protected from harm and the right to seek redress for wrongs are then considered, following which is an examination of the rights to communication and visitation. As in the case of mental health review tribunals, it is argued that the legislation demonstrates a concern for recognising and supporting psychiatric-centred perceptions of patients' needs (and, perhaps, their own needs) rather than the establishment of a compromise.

This situation, it is argued, places the evolution of legal services, particularly in Canadian jurisdictions, in a phase of continuing conflict. Lawyer and patient-centred perceptions of need are not being given sufficient credit and, consequently, aggressive partisan advocacy will continue. This, it is argued, is an unfortunate state of affairs given the apparent potential for compromise and the possibility of a productive relationship between mental health staff and legal services.

In the final chapter, this issue is pursued in some depth. It is suggested that a principal problem in the context of competing perceptions of need lies with the quest for patient power in the doctor/patient relationship. This issue of client power simply reflects, it is argued, the '*leit-motif*' of the legal aid movement as a whole. In the evolution of legal services the extent to which power is established for clients, in relevant relationships, determines the approach, or delivery style, that legal services adopt. In this context, the 'phases' of the process of legal service evolution are identified. It is argued that a 'patient welfare' approach to the delivery of legal services is a preferable situation to establish. However, in order to achieve this condition it is first necessary to establish patient power in relevant relationships. The elements of a 'patient welfare' approach are outlined. In particular, the notion of the poverty law practitioner as a member of a 'therapeutic' or 'treatment' team is discussed. An example of a mental health treatment setting where patient power has been established is cited as evidence of the feasibility of such a situation being satisfactorily established. The Chapter and the thesis close by identifying the areas of further research that are required; in particular, research that explores the establishment of legal services adopting a 'patient welfare' approach and the continuing need for partisan advocates especially in the context of proceedings testing the validity of involuntary commitment.

The data that forms the basis of this thesis have been accumulated from many sources. Cases were drawn from the numerous discussions of mental health law issues, from mental health law texts and reporters, and, in the case of Commonwealth jurisdictions, from abridgements and digests. Considerable legal research has, therefore, been undertaken. Information pertaining to legal services was obtained either through correspondence with relevant bodies or as a result of direct dialogue. In this respect, the writer undertook considerable travel during 1980. The main research commenced in September 1979, in British Columbia, and was concluded in January 1981 in Halifax, Nova Scotia. Between these two dates research was conducted during visits to Australia, England and several Canadian provinces. It has been, therefore, a Commonwealth venture; an appropriate situation given that the research was conceptualised and conducted whilst the writer was in receipt of a Commonwealth Scholarship.

NOTES

1: By 'legal services' I do not mean the range of resources or facilities provided by legal aid agencies or private legal practitioners. Rather, I am referring to the organisations, agencies or branches of agencies designed and established to deliver legal assistance to a community whether a geographical community or a community of people sharing an interest, such as mental health patients. Definitions of the term 'legal services' vary (see, e.g., Pfennigstorf & Kimball,1975) some writers using the expression to describe only the resources or facilities provided by lawyers. In this thesis the term should be read to mean the agencies or organisations involved in legal aid delivery.

2: This has been the experience of this writer whilst employed in legal aid delivery in Australia.

II. MENTAL HEALTH LAW: UNITED STATES AND COMMONWEALTH DEVELOPMENTS

The origin of the 'revolution' in mental health law is not easy to determine with precision. Many writers, discussing the evolution of patient advocacy in general, have examined the declining efficacy and validity of the old parens patriae power vested in the state (particularly in the context of protecting 'incompetent' persons). Others have considered the inadequacy of existing mechanisms for giving effect to the power along with the inaccuracy of underlying assumptions related to the role, and the contradiction posed by the accompanying 'police' or 'social control' power (Sadoff & Kopolow,1977; Roth,1980; Robbins,1980; Wolfensberger,1972; Anand,1979; Wald & Friedman,1978; Brakel & Rock,1971; Kindred, et al,1976). It has been suggested that the interaction of these three factors and especially the spectacular failure of the state to protect individual patients from the excesses of poorly equipped and financed mental health systems, produced situations that drew the attention of civil rights activists, primarily in the United States.[1]

Kopolow & Bloom (1977) and others (Sadoff & Kopolow,1977; Rubin,1978; Wald & Friedman, 1978) suggest that the notion of specific rights for the mentally ill was first articulated by

Morton Birnbaum. In an article discussing the 'right to treatment' he advanced a now familiar argument.

> "The fact that a person has a mental ailment is not a crime. Therefore, if anyone is involuntarily restrained of his liberty because of a mental ailment, that state owes him a duty to provide him reasonable medical attention. If medical attention reasonably well adapted to his needs is not given, the victim is not a patient but virtually a prisoner." (Birnbaum,1960:501)

This concern with the liberty of the individual and with drawing comparisons between mentally ill patients and prisoners has tended to be the '<u>raison d'etre</u>' for involvement by legal workers in protecting or pursuing the interests of mental health patients.[2] Similarly, Birnbaum's argument raised a number of additional issues that were to be formulated as 'rights' in subsequent court decisions; particularly, the right to reasonable treatment if incarcerated and the right to the least restrictive alternative to institutionalisation where the state is unable to provide treatment.

Involvement by legal workers and writers fused with, perhaps drew inspiration from, or perhaps contributed to, critiques of mental health systems generated in the 1960s by Szasz(1961,1965,1975,1977), Goffman(1968), Scheff(1966), Kittrie(1971) and others (Laing,1967; Laing & Esterson,1964; Foucault,1967). This is a concern that continues to attract the attention of writers (e.g. Anand,1979; Magaro, <u>et al</u>,1978).[3] Such critiques were and are, grounded in an interest in the growth of the 'therapeutic state', a suspicion that the mental health system had/has evolved into 'humanitarianism gone mad' and a realisation that there had/has been a questionable fusion of the criminal justice and mental health systems both in fact and in theory (Stone,1975; Sadoff,1978). In particular, writers were and still are, concerned about the problems of distinguishing the 'sane' from the 'insane';[4] the diagnosis and treatment of mental illness; the process of discriminatory institutionalisation;[5] the effects of institutionalisation, the techniques of behaviour control and modification; and the bases upon which people are involuntarily committed to institutions.[6]

Certainly it appears that there was an early recognition that the law could be a potentially powerful source of aid in promoting reform[7] and that lawyers existed who might be able to provide assistance(Szasz,1965; Ennis,1972; Wald & Friedman, 1978). However, whether such lawyers were perceived as the only mechanism by which the relentless march of the therapeutic state could be halted is unclear.[8]

It is apparent, however, that their potential in relation to resolving immediate and less macroscopic concerns was recognised particularly after patients' rights groups and civil liberties attorneys (again, principally in the United States) began litigation and the courts withdrew from their former 'hands-off' policy in passing judgements in matters involving the efficacy of medical treatment(Kopolow & Bloom, 1977; Bazelon,1969; Stone,1975; Burris,1969; Brakel & Rock,1971;

Kindred, et al,1976). Mental health law and lawyers then became embroiled in what have been described as 'first generation' issues, such as the right to treatment for institutionalised individuals and proper standards and procedures for civil commitment, passing to 'second generation' issues such as the right to the 'least restrictive alternative' in treatment programmes, the right to periodic review whilst in an institution and the right to refuse treatment (Mental Disability Law Reporter,1976).[9] A number of landmark cases in the United States established rights and precedents that were to have a profound impact on developments throughout the 1970s, beyond the jurisdictions in which they occurred.[10]

Lessard v Schmidt,[11] a case recently described by Roth (1980) as the "bellwether for the decade," established substantial rights and protections for the involuntarily committed, notably in relation to commitment procedures.[12] Rouse v Cameron,[13] recognised as the landmark case in the pursuit of the right to treatment, reversed the 'hands-off' doctrine, the court being concerned, for the first time, with the processes occurring inside mental health institutions.[14] In a similar vein, Wyatt v Stickney,[15] a class action that has generated extensive discussion and criticism[16] (Stickney,1974; Wald & Friedman,1978; Schwartz,1974; Leaf,1977; Rivenbark,et al,1977; Heller, 1977; Dorman,1977; Condom,1977), involved a court ordering specific standards of treatment to be applied to a state mental health system (Brieland & Lemmon,1977; Ennis,1973). Wyatt v Stickney, along with the 'Willowbrook' case (N.Y.S.A.R.C. and Parisi v Carey),[17] has also been seen as the major step towards widespread deinstitutionalisation (Rubin;1978), whilst Donaldson v O'Connor[18] maintained the impetus by, inter alia, establishing in the case of involuntarily confined people, a constitutional right to individual treatment that would aid release.[19]

Dixon v Weinberger[20] established the right to treatment in the least restrictive setting; Jackson v Indiana,[21] safeguards against indefinite confinement (specifically in 'fitness' cases). Baxstrom v Herold[22] challenged the concept and definition of dangerousness and Souder v Brennan[23] brought patient-workers within the scope of the federal Fair Labor Standards Act. Rogers v Stanley,[24] Heryford v Parker[25] and In Re Popp[26] assured persons who were or were about to be, involuntarily committed, the right to counsel and the right to assigned counsel if indigent.[27]

As Wald & Friedman point out (1978), the essence of these (and other major) decisions "has been incorporated into both state laws and federal legislation" (op cit:137). In addition, the issues raised have instigated a number of national enquiries in the United States, including those conducted by the President's Committee on Mental Retardation (1976) and the Senate Sub-Committee on the Constitution (1977)[28] which, in turn, have generated further relevant legislation.[29]

Whilst the litigation approach to mental health law has continued, the early cases have not been matched in impact by more recent judgements. Indeed, as many writers have recently observed (Roth,1980; Scallett,1980; Stone,1979), there is some evidence to indicate that the courts are turning to consider, more thoroughly, the psychiatric viewpoint, before handing down judgement.[30] The rulings in two recent cases, Addington v Texas,[31] a case involving the standard of proof to be applied in civil commitment proceedings, and Parham v J.R.,[32] a case involving the commitment of children to hospitals, both support such a proposition. This is adequately illustrated by the dictum in the judgement of the United States Supreme Court, in the latter case;

> "We do not accept that the notion that the shortcomings of specialists can always be avoided by shifting the decision from a trained specialist using the traditional tools of medical science to an untrained judge or administrative hearing officer after a judicial-type hearing. Even after a hearing, the non-specialist decision-maker must make a medical-psychiatric decision..."

Thus although other recent cases, for example, Rennie v Klein,[33] Rogers v Okin,[34] French v Blackburn,[35] and Project Release v Prevost,[36] might continue the impetus of the major landmark cases, an entirely new trend is becoming apparent - a guarded return to the primacy of the medical model (a process that may generate a batch of 'third generation' issues).

To some extent this trend may be due to the apparent, deleterious side effects of the so-called 'over-reach' of civil rights lawyers.[37] It is also possibly due to the recent advancement of patients' rights as perceived by mental health professionals and also the advancement of the rights of such professionals, as advocated by their professional bodies. This is not to say that such rights are necessarily at odds with those presented by lawyers on behalf of patient groups. As Armstrong (1979) has pointed out, the poor working conditions in hospitals are often causal factors in conflicts between staff and patients. The former are often injured in confrontations and may lobby to have, for example, a ward closed down as an unsafe work environment; a claim which, if successful, could lead to better patient care (e.g. through the building of new premises).

Davis (1978) has provided a comprehensive list of patients' rights (at least, for chronic patients) from the perspective of hospital staff. None of the rights appear to be especially in conflict with patients' rights espoused by patients' groups, although the right to <u>have</u> treatment is strongly emphasised and directed more towards the individual patient than is the case in relation to the civil rights lobby.[38]

The American Psychiatric Association, at a recent conference,[39] advocated seven basic rights for professionals the substance of which are again oriented more to the individual treatment setting but which adequately summarise their needs in the pursuit of effective health care for patients (Editorial,1976).[40] A concern for more widespread needs, including the right to have sufficient resources for health care and the right to participate in the allocation of resources and treatment setting priorities, has been articulated by Gibson (1976).[41] Although his position could be seen to correspond with that advanced by mental health lawyers in that the principal thrust is towards improving the opportunities and conditions necessary to provide effective health care, his concern with, for example, a right to practice without excessive and unnecessary regulation, could be construed as an attempt to oppose, if not negate, the controls placed on psychiatric practice by the courts.

Whilst the advancement of such rights could be interpreted as reflecting a desire, on the part of mental health professionals, to increase the adversarial character of the overall debate (a possibility that is implicit in Stone's (1979) recent call for the American Psychiatric Association to hire lawyers to advance the Association's position before the courts (see also Peek,1980)), there is an equally strong concern for reaching a functional compromise in the enduring conflict between health needs and civil rights needs. Both lawyers (e.g. Schwartz,1974; Slovenko,1977; Hansen,1975) and psychiatrists (e.g. Scallett,1980; Peek,1980; Roth,1979,1980; Talbot,1980; Stelovick, 1979; Schmolling,1975; Peele,1975) have voiced a concern that the 'battle' between the two professional factions is being carried on at the expense of the patient (see also Barton & Sanborn,1978; and Appelbaum & Guthiel,1979); a realisation that has generated alternative approaches to pursuing the interests of clients of the mental health system. In particular, the concept of 'citizen advocacy'[42] (Wolfensberger & Zauha,1973) tied to the theory of 'normalisation' (Wolfensberger, 1972),[43] is gaining popularity in the United States and Canada (Wolfensberger,1977; Coye,1977; Van Ness & Perlin,1977; Schmidt,1977).[44] As a multi-component scheme for the advancement and protection of the needs and rights of patients outside of the problematic, adversarial setting established in the early 1970s, it holds promise (but nothing more) as a solution to the vexed issue of how to best serve the interests of a special group of disadvantaged people.[45]

Unlike the United States, major developments in mental health law in other jurisdictions (notably those in the British Commonwealth) have been by way of law reform initiated in legislatures rather than through the courts. This situation tends to reflect the entrenched differences between Commonwealth and United States legal systems as they pertain to pursuing issues in the 'public interest' (to be dealt with more thoroughly later in this thesis). However, this is not to suggest that lawyers have been entirely inactive in pursuing the interests of mental health patients even if the reformative effects have not been as spectacular (at least on paper) as those attained in the United States in the 1970s.

In this respect it is possible to offer the provocative suggestion that significant Commonwealth developments related to issues of current concern occurred some time before those in the United States. The vintage of much of the relevant case law in relation to Canadian jurisdictions suggests such a possibility. For example, in a 1927 case before the Alberta Supreme Court (Hibberd v Jamieson),[46] Simmons C.J. appeared to at least recognise the need for the legal representation of patients in mental health cases, whilst a 1960 case in Manitoba (Burke v Efstathianos),[47] appears to move towards a right to treatment in the case of involuntarily confined patients. In the latter, Simmons J. stated that an Act authorising such confinement should be construed according to its spirit, namely, assisting the patient. It was not a penal statute and therefore should be construed liberally. A 1959 case from the Quebec Court of Appeal (Dame L v Larve,[48]) dealing with the criteria for involuntary commitment, ruled that 'dangerousness' should be the only ground upon which such a confinement should proceed; danger being defined as the threat of physical or other serious damage to self or others.

Whilst some of these judgements eventually found their way into the relevant legislation (e.g. The Mental Patients Protection Act SQ 1972 c.44, in the case of Dame L v Larve) it is acknowledged that their overall impact was considerably less than corresponding (but later) judgements in the United States. It is also apparent that litigation has been concerned with ensuring that patients are adequately protected from the wrongful actions of mental health professionals rather than attempting to establish reforms in existing mental health systems. As such, test cases have touched on the issues advanced in the United States, where such issues have been related to the substance of an action (e.g. the right to receive remuneration for work undertaken in hospitals), but have not, themselves, resulted in substantial and dramatic change.

In a major review of Canadian and British mental health cases, particularly in relation to a right to treatment, Yake (1973) points out that because of the lack of a firm constitutional basis, "British and Canadian cases... have proceeded case by case to object to specific deficiencies in treatment" (op cit:5), a situation repeated in other jurisdictions such as Australia and New Zealand.[49] This has resulted in a general disorder in the law not unfamiliar to students of other specialist areas,[50] in part because of an apparent reliance on certain assumed common law rights (e.g. a right to treatment evolved from the medical practitioners 'duty' to treat)(Somerville,1979; Katz,1970) and a right to refuse treatment in the case of any competent person (see Gostin,1980);[51] in part because of the lack of a unified approach to pursuing rights and liberties (the lack of a legal lobby); and in part because of a failure to extend the protections in legislatively established Bills of Rights (notably in Canada) to the situations covering, amongst other people, mental health patients. Draper (1976a), for example, has recently suggested that involuntary admission, by certification, to Alberta mental health institutions, is an invalid process in the face of Section 1 of that province's Bill of Rights (a 'due process' clause). His trenchant and well researched argument (see Draper,1976a; Draper & Williamson,1976) has not resulted in procedural reform in that, or any other province, or the testing of his argument before a court. This is hardly suprising in the light of the fate of other attempts to invoke the protections of Bills of Rights in relation to similar (e.g. the right to counsel in due process hearings) and related issues.[52]

Yake's comment (1973), quoted above, implies that an examination of even major developments in the past ten years would be beyond the scope of this thesis; he concludes,

> "...(t)here has been no reported Canadian test case...where the law was clearly stated with regard to the treatment that mental patients have a right to expect. This is not to infer that there has been no treatment accorded patients which could have formed the basis for such a case." (op cit:16)

The same problem exists in relation to consent to treatment (and the right to refuse treatment), competence to consent, voluntariness and knowledgeability (op cit). Further, as Page has pointed out (1973), the problem of the absence of test case litigation extends to the area of tort, especially in relation to negligence, with a failure to establish clear precedent in respect of the conduct of those providing treatment to mental health patients (other than that supportive of an omnibus duty of care). Indeed as Yake has pointed out, (1973:107), "(c)ourts have been charitable to medical men (sic) who err in Canada. In most instances, especially where a mental patient or a symptom of mental illness is concerned, doctors have been absolved," an approach which appears, as might be expected, to reflect the dominance of English rather than United States precedents.[53]

A similar problem and equal confusion is found in the area covering procedures for admission to hospitals and related liability. Draper's study in Alberta (1976b), which involved an analysis of Canada-wide cases, failed to find any consistent doctrine other than a persistent concern that wrongful, compulsory admission should be avoided and an apparent willingness to award appropriate damages (for wrongful imprisonment) where doctors wrongfully certify someone as mentally disordered and dangerous (Schmidt v Katz and Shrider).[54] Such cases simply reflect principles espoused in English and Canadian courts over the past 100 years,[55] although it should be noted that an action does not lie solely on the ground that the certifying doctor has come to a wrong opinion (Williams v Beaumont and Duke),[56] providing he or she is exercising both good faith and reasonable care (*Everett v Griffiths*).[57] A more recent case on wrongful admisssion (*Columbia v Watier*)[58] before the Supreme Court of Canada has not clarified the overall situation.

In other areas of importance to mental health patients, litigation in Commonwealth jurisdictions has been restricted. Although, as many writers point out (Nash,1976; Gostin,1980; Swadron & Sullivan,1973; Draper & Williamson,1976; Alper, 1978), patients are systematically denied a wide range of civic and civil rights (e.g., the right to vote, the right to hold office, the right to practice in certain occupations, the right to operate a motor vehicle) actions to protect or restore these rights have been limited. Nash(1975) reports that some success has been achieved, in England, in relation to the right to vote. Further, a British Columbia class action, *Re Lemay*, dealing with the conditions of employment of institutionalised mental health patients, awaits a trial date following an examination for discovery. *Rosandick v Manning*,[59] also from British Columbia, established a patient's right to use counsel to question his or her commitment even though the patient's affairs had been placed in the hands of the Public Trustee following a declaration of 'incapacity'. Whilst these developments are important and useful they have not had the same impact as similar cases in the United States.

However, Rosandick v Manning (supra) serves to highlight a further problem of considerable importance that has attracted litigation in England and Wales: the issue of the right of access to the courts. As Gostin (1977,1979,1980) and others (Venables,1975; Bacon,1975; Miller,1979) have pointed out, Section 141 of the Mental Health Act 1959 (England and Wales) requires leave of the High Court before any proceedings may be taken against a person acting under the provisions of the Mental Health Act,[60] a situation that has led to considerable injustice. In R v Bracknell Justices, ex parte Griffiths,[61] for example, (also known as the Poutney case) a matter involving an assault committed by a nurse on a patient, the action was vacated on appeal to the House of Lords, as the complainant did not first obtain an authority from the High Court to proceed. Despite the clear evidence of the 'guilt' of the nurse[62] the matter was lost for want of procedural precision. Efforts are now being directed towards a revision of this restictive section of the Act by applying the precedent established in Golder v United Kingdom, a 1975 case before the European Commission on Human Rights.[63] In Golder it was held that institutionalised people (in this case, prisoners) should have unimpeded access to the courts and that the United Kingdom government was in contravention of that right by limiting access. In a prompt response the Home Office issued new rules for prisons but no similar action was taken in relation to Section 141 of the

Mental Health Act.[64]

Restrictions on gaining access to the courts are found in other Commonwealth jurisdictions.[65] Under such circumstances it is hardly surprising that lawyers working in the mental health area are unable to pursue cases and produce effective reforms on behalf of mental health patients, with the same vigour as their United States colleagues. Indeed it seems that, in Commonwealth jurisdictions, lawyers acting on behalf of mental health patients are having difficulty in establishing that their clients are entitled to certain usually unquestioned protections enshrined by basic legal and judicial principles.

The conduct of tribunals established by mental health and other relevant legislation to provide a review facility for patients has been subjected to discussion in England (Gostin & Rassaby,1980) and Canada (Shone,1976; Sharpe,1980; Savage,1980).[66] In both countries attempts have been made to have the rules of natural justice[67] extended to cover tribunals which are, it has been argued, effectively bodies under a duty to act judicially and therefore subject to such rules (Gostin & Rassaby,1980). Litigation on this question, sponsored by MIND in England (as reported by Gostin & Rassaby,1980), was unsuccessful despite the employment of the newly developed principle that suggests that, even as administrative rather than quasi-judicial bodies, review boards have duty to act fairly.[68] It should be noted, however, that the action pursued (R v Secretary of State for Home Dept., ex parte Powell)[69] was in relation to a 'restricted patient' who had been the subject of an hospital order under Section 60 of the Mental Health Act 1959 (England and Wales) and who had been originally convicted of what Goff J described as "an offence of considerable gravity" involving a 9 year old girl. The question of whether or not a court would have handed down a different judgement where the patient's status and antecedents were different (e.g. an involuntary patient without a history of 'dangerous' criminal behaviour) remains moot.

In Powell's case, a multi-disciplinary case conference had recommended that the patient be conditionally discharged. His case had been referred to a new and somewhat mysterious review body known as the 'Aarvold Board' (The Advisory Board on Restricted Patients)[70] who had recommended to the Home Secretary that Powell not be discharged. Whilst the Board's function is purely advisory (in theory) it has been shown that, in effect, the Home Secretary rarely fails to accept the recommendations that are made.[71] Because of this fact it was argued, in Powell, that the Board is actually a decision-making body and, therefore, subject to the rules of natural justice, such rules not having been followed in Powell's case. The argument was not accepted by a majority of the court. The issue is of importance because, as Gostin & Rassaby point out (1980) it means that a fair hearing before an ordinary review tribunal, "may be a meaningless safeguard for the patient whose case is submitted subsequently to a review body which will effectively take a decision without providing him or his representative with an opportunity to be heard."(op cit:58)

In Canada, Shone's persuasive argument (1976) that review boards established under the Alberta, Mental Health Act (RSA 1972 c.118) were denying natural justice to appellants, produced no apparent response on the part of relevant authorities. This is not to suggest, however, that the issue has not come before the courts. In the context of Lieutenant Governors' Advisory Review Boards set up under Section 547 of the Criminal Code, issues similar to those raised in England have been debated. As such, argument has revolved around whether or not the Boards play a purely advisory role. In Re Lingley and Hickman[72] the court ruled that the function of such boards, as administrative tribunals, was only advisory. The Lieutenant Governor in Council was the person who made the final decision on a Board's investigation and report. This view was confirmed in Re Lingley and the New Brunswick Board of Review[73] and in a later case in relation to another 'administrative' tribunal alleged to be making 'decisions' - the National Parole Board (Howarth v National Parole Board).[74] However, commentary in these latter cases tended to confuse the issue for, as Linden points out (1980), when addressing the issue of relief in both instances, the courts made reference to the fact that the 'decisions' of such bodies were not subject to review.

This confusion, however, may only pertain to the issue of remedy in cases where a denial of natural justice, or other wrong, may occur. For example, in Re Lingley and Hickman (supra), it was apparent that the power of the court was limited to declaratory relief, a situation which, as Sharpe has recently argued (1980) may be changing in favour of more effective remedies. What is clear is the collapse, in the context of the conduct of hearings, of any distinction between the role of Boards as judicial/quasi-judicial bodies and their role as administrative tribunals. This is particularly the case where the rules of natural justice and the duty to act fairly are in question. Thus in Re Abel, et al, v Penetanguishene Mental Health Centre[75] the Ontario Divisional Court ruled that although Boards established under the Ontario Mental Health Act (RSO 1970 c.269), had a purely advisory function they were nevertheless under a duty to act fairly and the rules of natural justice applied to their activities.

This has been reinforced by the judgements in two more recent cases. In Martineau v Matsqui Institution Disciplinary Board[76] the Supreme Court of Canada ruled that a prison disciplinary board has a duty to act fairly even if it is 'classified' as an administrative, rather than judicial/quasi-judicial, tribunal. Similarly, in Re Abel, et al, and Advisory Review Board[77] the Ontario Court of Appeal not only stressed that boards had a duty to act fairly, but also seemed to extend this duty to encompass the disclosure of relevant information to an appellant's lawyer. In a qualification of the earlier Abel decision (supra) the court indicated that such a duty existed notwithstanding any discretion that may be allowed to a review board in relation to the provision of information.[78] In this respect, a summary of the judgement in Re Abel (supra) assists an appreciation of the current, general situation.

> "Whether a board or tribunal's function is characterised as being judicial, quasi-judicial or administrative, a duty to act fairly has been recognised where its decision will affect the rights, interests, property or liberties of any person or it will be investigating and making a report that may result in a person being subjected to "pains or penalties" or in some such way adversely affected by the investigation and report. The decision or investigation of the Advisory Review Board is of this kind. The whole purpose of the establishment of an advisory review board was to create an independent body, bringing to its task a considerable and varied expertise of its own, and likely to develop quickly an even greater expertise with the kind of problem assigned to it, with the hoped-for result that no one would be kept indefinitely in a mental institution, half-forgotten, and with his situation unreviewed except by the staff of the institution. It is inherent in the conception and operation of such a board that its recommendations will virtually always be accepted. The Chairman of the Board therefore erred in refusing to disclose any information on the ground that he had no authority to do so. His authority to make disclosure to the applicants' counsel derived from the duty imposed upon him and the other members of the Board to act fairly...If lawyers are to properly represent their clients they need to know the substance of the facts placed before the Board although there may be specific facts which for good reason the Board may properly decide should not be revealed. Further, the board may impose terms when disclosure is made. Thus there may be cases where information might be disclosed to a lawyer on terms that it not be disclosed to the client."(op cit:153)

In general, this situation seems to bode well for the future conduct of review boards in both the criminal and civil contexts. In the case of provincial review boards dealing with civil commitments it is, I would argue, clear that such boards are decision-making, as opposed to advisory, bodies. However, this distinction and the attendant issues, may be redundant beyond the specific question of which remedy should be applied. Whatever their status, it is apparent that the courts recognise that in the conduct of their hearings, they have a duty to act fairly and are required to observe the rules of natural justice. This will become of increasing importance as the activities of such boards are exposed to scrutiny by practitioners specialising in mental health matters.[79]

This is particularly pertinent given that the conduct of review boards concerned only with patients committed because of criminal behaviour has recently come under scrutiny in Canada. Whilst the Lieutenant Governors' Advisory Boards, established by the provinces do not appear, in general, to operate in the same fashion as the previously mentioned Aarvold Board (Haines,1978,1980; Savage,1980) the decisions of at least one board have led to considerable criticism. The matter of Emerson Bonnar, until recently (February,1981) detained under a Lieutenant Governor's Warrant in a New Brunswick institution, has placed their work under a spotlight. Indeed, Bonnar's case, now being pursued by the National Legal Resources Service of the

National Institute on Mental Retardation, may prove to be a landmark in Canadian mental health law.

It appears that as a result of initial errors in relation to his original confinement and the circumstances of his detention Bonnar may have become "severely institutionalised", his current mental health condition being "attributable to the conditions of his confinement, more than to any pre-existing disorder"(Endicott,1980:2). Quite apart from issues pertaining to the decision-making process of advisory review boards and the quality of their subsequent recommendations, the Bonnar case raises the possibility of an action in tort against the provincial government and other relevant parties, not only for an unwarranted deprivation of liberty but also for having, perhaps by their original and continuing negligence, contributed to Bonnar's current state of mental ill-health. The progress of any such action may be expected to have a broad impact on mental health commitment procedures in Canada, beyond the specific circumstances, particularly if it is pursued to a successful conclusion (e.g. the award of substantial damages). Indeed, this consideration may have been behind the reluctance of the New Brunswick government to, until quite recently, do more than 'loosen' the Lieutenant Governor's Warrant permitting Bonnar's transfer to a standard psychiatric institution.[80]

Against this general background of activity in the area of mental health law, significant developments have taken and are taking place in relation to the provision of legal services for mental health patients. Indeed, I would argue, there is considerable evidence to suggest that, in fusing their mutual interests, those working in the area of mental health and those working, in particular, in the area of legal aid delivery have produced a situation that can be seen to be a major impetus in the continued pursuit of patients' rights and other legal needs; particularly, as I will point out in the next Chapter, in Commonwealth jurisdictions.

NOTES

1: Although there is some evidence to suggest that concern was widespread (see note 2 below), the major activity occurred in the United States. On the one hand, it is argued that pre-existing structures (notably legal traditions and mechanisms) permitted this process to occur more rapidly in the United States. On the other hand, it is possible to argue that the conditions prevailing in public institutions in that country generated a greater, perhaps more urgent, need than in other locations. See, for example, Rivera,1976; United States Senate Sub-Committee on the Constitution,1977. The actual reason is unclear.

2: Reference to the issue of the deprivation of liberty is continually made in the writings of those involved in the area of mental health law.

3: For a critique of the critics, see Martindale & Martindale,1973.

4: See, in particular, the oft-quoted and criticised article by Rosenhan(1973) in which he concludes "the normal are not detectably sane."

5: Race, class and sex discrimination have been documented. See, Anand(1979), for a concise summary.

6: Including the vexed issue of how to determine dangerousness. See, in general, Weisstub,1980.

7: In Law, Liberty and and Psychiatry (1965), Thomas Szasz wrote,

> "...perhaps the most effective method for securing the mental patient's liberty - not to become mentally well, but, if need be, to remain as he is and yet enjoy the rights of an American - lies in legal action against his oppressors." (p 253)

8: There is no documentation of such a global assertion or ambition. However it is apparent that the ensuing litigation and responses thereto, coupled with changes in the treatment of the mentally ill, have raised effective barriers to such a development. At a theoretical level Phillip Reiff, whose book The Triumph of the Therapeutic (Harmondsworth: Penguin, 1966), raised the spectre of a therapeutic state growing with the development of 'psychological Man', has recently recognised the decline of the trend and is preparing a new text 'The Return of the Paternalistic' in which the change is documented (personal conversation at La Trobe University, Melbourne, Australia; August, 1980). At a practical level, the number of 'landmark' cases in mental health law has dwindled (suggesting the absence of suitable issues demanding reform), the concept of law reform in mental health areas has spread to a number of countries (e.g. Canada and Australia), and the various bodies representing mental health professionals have accepted greater controls on and increased accountability in relation to, their work. In a recent article in Hospital and Community Psychiatry (the mouthpiece of the American Psychiatric Association), Pardes & Pincus (1980) describe the 1970s as a decade of refinement in mental health treatment, pointing to five major developments responsible for the significant changes that have occurred. The pursuit of civil rights concerns and the growth of consumerism are seen as having influenced the quality and location of mental health care. In addition, mental health issues (including those involving the criminal law) have been subjected to scrutiny and criticism by academics (see, e.g. Weisstub,1980) and government enquiries (England and Wales Royal Commission on the Mental Health Act,1959; The New South Wales Government Enquiry into the Mental Health Act,1958 (The Edwards Committee); President's Committee on Mental Retardation; The Law Reform Commission of Canada). It is argued that these developments indicate that legal intervention has had a marked impact on the growth of the 'therapeutic state'. As a consequence they perhaps now invalidate the theoretical premise, particularly popular in the 1960s, that the medical (or therapeutic) model for explaining social control processes is the most effective.

9: A seemingly contradictory issue, vis-a-vis the right to have treatment, unless it is perceived in light of the 'general' and the 'specific'. A 'right to treatment' has come to be associated with establishing proper facilities in institutions and avoiding the process of 'warehousing'; that is, creating widespread reform in mental health systems that affect all patients (most cases have, in fact, been class actions). A 'right to refuse treatment' is associated with the needs of individual patients or with attacks on treatment modalities affecting a class of patients and that are considered of questionable value or have unacceptable consequences (e.g. psycho-surgery).

10: Whilst the precedents and specific rulings were, obviously, only marginally tenable beyond their jurisdictions (given the doctrine of stare decisis) the concepts generated by such cases have been accepted or are used internationally. See, for example, the proceedings of the Ontario Standing Social Development Committee(1978) formed to consider amendments to the provincial Mental Health Act; and the proceedings of the Edwards

Committee of Enquiry (1975) into the New South Wales *Mental Health Act*).

11: 349 F.Supp 1078 (E.D. Wisc 1972)(subsequent history omitted).

12: This may be partly disputed in that two earlier cases, *Williams v Overholser* 104 US App DC 18: 259 F2d 175 (1958) and *Lynch v Overholser* 369 US 705 (1962) appear to deal with the issue and establish certain procedural rights. See Roth(1980) for an excellent summary of *Lynch v Overholser*.

13: 125 US App DC 336 F2d 451 (1966)

14: There is some dispute over the primacy of *Rouse v Cameron* as it appears that a much earlier case, *Miller v Overholser* 206 F2d 415 (DC Cir 1953), may have established the right to treatment. In brief, the judgement in the latter case suggested that if a person was placed in an institution then he or she should receive therapy, if that is the rationale for commitment. Similarly, in *Ragsdale v Overholser* 281 F2d 943(DC Cir 1960), a case dealing with a person declared to be criminally insane, it was held that a person committed to an institution had a right to treatment. If such treatment was not provided then the hospital was, in fact, a prison (see Birnbaum, 1960).

15: 325 F Supp 781 (MD Ala 1971); 334 F Supp 1341 (MD Ala 1971); 344 F Supp 373/387 (MD Ala 1972). Continuing as *Wyatt v Aderholt*, and *Wyatt v Hardin*(subsequent full history omitted).

16: Schwartz(1974) and Rubin(1978), for example, point out that the 'first' *Wyatt v Stickney* case was brought, not on behalf of patients, but on behalf of a group of mental health professionals who were dismissed following a budget cut. The issue of the right to treatment was raised in support of *their* position but then became the focus of the case as a *patients'* issue.

17: 393 F Supp 715 (EDNY 1975). This case also established a right to protection from harm.

18: 493 F2d 507 (1974). Also *O'Connor v Donaldson* 422 US 563 (1975) in which damages were awarded for the continued detention.

19: It is apparent that judgements in both the *Donaldson* and *Wyatt* cases have been closely inter-related. In *Wyatt v Alderhot* 43 USLW 2208 (5th Cir 1974) for example, the court ruled, affirming the Donaldson decision, that the right to treatment could be implemented through judicially manageable standards and that the District Court had not invaded the province of the legislature in requiring the preparation of a plan for treatment of civilly committed mental patients (see Wald & Friedman,1978, for the continuing debate in relation to this issue of encroachment).

20: 405 F Supp 974 (DDC 1975)

21: 406 US 715 (1972)

22: 383 US 107 (1966)

23: 367 F Supp 808 (DDC 1973)

24: 17 NY 2d 256; 217 NE 2d 636; 270 NYS 2d 573 (1966).

25: 396 F2d 393 (10th Cir 1968)

26: 33 Ohio App 2d 22; 292 NE 2d 330 (1972)

27: As in notes 11 and 13 <u>supra</u>, this may be disputed. An earlier case <u>Dooling</u> <u>v</u> <u>Overholser</u> 100 US App DC 247; 243 F2d 825 (1957) appears to establish a right to counsel in civil commitment processes although it also stresses that such a commitment and the use of a lawyer should not occur in an 'adversary' setting. Thus, although the right may have been established it could be seen to be qualitatively different than the right enshrined through the more recent cases cited.

28: An enquiry to consider a Bill authorising the Federal Attorney-General to take action in relation to the constitutional rights of institutionalised people.

29: In this respect the latest developments relate to the Mental Health Systems Act Title 3, which, according to Scallett (1980), will provide the advocacy provisions recommended by the President's Committee (1976), but excluded from the original Act. The provisions were included in the Senate in the Javits amendment (Senator Javits, Republican, New York), subject to some redrafting and now awaits final passage (not yet law at April 1981). It is interesting to note two developments that may adversely affect the progress of the legislation: i) Senator Javits was defeated in the November 1980, United States elections; and ii) in March 1981, the Reagan administration proposed cutting the mental health services budget by 25% (Life, May, 1981).

30: Due, in part, to the frequent presentation of amicus curiae briefs by the psychiatric profession, through its various organisations, and governing bodies, before courts handling mental health law matters.

31: 99 S Ct 1804 (1979): reduces the standard of proof from 'beyond reasonable doubt' to 'a preponderance of the evidence.'

32: 99 S Ct 2493 (1979). The <u>ratio</u> is summarised as follows:

> "Absent evidence of clear-cut abuse and neglect by parents, or evidence that the psychiatrists who had admitted the children had acted in bad faith, a majority of the court saw no constitutional necessity for requiring complex procedures to review the admission of the children. Review of the parents' request by a neutral and independent physician is, however, constitutionally required."(Roth,1980:393)

In this case the U.S. Supreme Court were referring to established due process proceedings and clearly have reversed the situation established by, for example, <u>Heryford v Parker</u>.

33: 462 F Supp 1131 (NJ DC 1979): held that involuntary patients have a right to refuse chemotherapy and generally imposing stringent controls on when persons can be given drugs against their will. The court expressed its concern in relation to overmedication of patients and the consequent side-effects (notably tardive dyskinesia).

34: CA No 75-1610-T(Mass DC 1979): as in <u>Rennie v Klein (supra)</u>, a case involving overmedication. The court also imposed controls on the use of drugs but, in addition, the court expressed its concern that such controls should not disrupt effective therapy.

35: 428 F Supp 1351 (1977): 99 S Ct 3091 (1979): a case concerned with the issue of when a pre-commitment hearing should be held in the case of involuntary patients (see also, Lessard v Schmidt (supra); Coll v Hyland 411 F Supp 905(1976); Lynch v Baxley 386 F Supp 378 (1974); Briggs v Arafeh 411 US 911(1973); Logan v Arafeh 346 F Supp 1265(1972)). In French, it was held that a hearing should occur within ten days of hospitalisation, a judgement that has shortened the permitted time period (formerly twenty days).

36: 78C 1467 (ERN) US Dist Ct, Eastern Div. of New York (1979): a case currently being litigated in relation to protection against 'self incrimination'; i.e. the use of psychiatric evidence in commitment hearings obtained from a patient in the course of a case interview by a psychiatrist (see also Lynch v Baxley (supra), and French v Blackburn (supra)). Specifically in question is the issue of whether or not a patient should be given a 'Miranda' style warning before a case interview.

37: This issue will be discussed more fully later in this thesis.

38: Davis lists the rights as follows:

1. The right to alternatives to hospitalisation.
2. The right to receive treatment from an array of staff.

3. The right to diversity of treatment modalities.
4. The right to physical as well as psychological examination.
5. The right to a clean, attractive and pleasant environment.
6. The right to one staff member as an advocate.
7. The right to appropriate psychotropic medicine.
8. The right to follow up after hospitalisation.

39: The 27th Institute on Hospital and Community Psychiatry.

40: Dr. Dean Collins, on behalf of the Association, listed the following rights:

1. The right to form an independent professional opinion.
2. The right to define one's own personal and professional limitations.
3. The right to detail a treatment plan effective in achieving goals.
4. The right to define the best clinical setting to achieve such goals.
5. The right to consult with colleagues of one's own choice.
6. The right to privacy in relation to the patient and his or her condition.
7. The right to terminate responsibility for a patient with reasonable notice.

41: Gibson argues for the following rights:

1. The right to have sufficient resources for health care.
2. The right to participate in the allocation of resources and in setting priorities.
3. The right to be accountable for clinical matters, to the highest government authority.
4. The right to free and complete exercise of clinical judgement and skill.
5. The right to review by peers.
6. The right to practice without excessive and unnecessary regulation.

42: Defined by Wolfensberger (1977) as follows:

> "An unpaid, competent, citizen volunteer, with the support of an independent citizen advocacy agency, represents - as if they were his/her own - the interests of one or two impaired persons by means of one or several of many advocacy roles, some of which may last for life."

The advocacy roles are summarised as follows:

1. A one-to-one relationship by which the volunteer "advances the welfare and interests of an impaired or limited person as if that persons' interests were the advocate's own."
2. Undertaking instrumental (problem solving) and expressive (emotional-affective) tasks consistent with the theory of normalisation.

3. Carrying out a wide variety of advocacy roles both informal and requiring formal recognition (e.g. being appointed guardian).
4. Receiving legal recognition and support.
5. The provision of an administrative mechanism to activate the scheme (e.g. local or regional advocacy offices).

43: The theory of normalisation involves the principle of minimal protection (just as much help as is needed but no more) as opposed to full and formalised paternalism (as resplendent in the old parens patriae power). As a corollary, it demands the encouragement of maximum independence on the part of impaired persons.

44: A full discussion of Canadian developments up to 1973 is provided by Zauha & Korn (1973). With the exception of Newfoundland, advocacy schemes exist in all provinces although their size and coverage varies considerably. In addition, advocacy for the mentally ill rather than the mentally retarded (and other groups, e.g., the aged and children), appears to be minimal.

45: This is not to suggest that citizen advocacy can operate without recourse to law. Accounts of operationalised advocacy services (e.g. Wolfensberger & Zauha,1973) indicate that access to a legal resource and undertaking legal actions are often necessary, being the only way to effectively pursue the interests of 'proteges'. Wolfensberger seems to readily recognise this fact by acknowledging that citizen advocacy has grown from but never outgrown, the concept of 'protective services' (e.g. conservatorship, adoptive parenthood, guardianship and trusteeship) which incorporates acting as the agent for a 'protected person' in relation to pursuing the interests of a 'protege' through the courts. Similarly he has pointed out that undertaking 'instrumental' tasks on behalf of a person will often involve legal action (see Wolfensberger & Zauha,1975; Wolfensberger,1977). Given the acknowledged importance of a legal component in citizen advocacy it is difficult to see how the concept will resolve conflicts between proteges (and lawyers acting on their behalf) and mental health professionals other than, perhaps, introducing, i) a greater provision for resolution without recourse to the courts, and ii) the possible prevention of conflicts before they arise. Such a process, clearly, operates best in the pursuit of individual interests but is not so effective in pursuing the needs of the group (that is, for example, all mental health patients within one state mental health system). However, it could be argued that the introduction of citizen advocacy is timely in that, following the implementation of the reforms generated by major class actions in the early/mid 1970s, the need for further legal advocacy in an adversarial setting is reduced and a less aggressive or more co-operative and individualised approach to reform is needed.

46: [1927] 3 WWR 543.

47: [1960] 32 WWR 641: this case coincided with the Birnbaum article (1960)(see my comments at the beginning of this Chapter) and suggests a number of intriguing inter-connections worthy of exploration.

48: [1959] Que QB 549 (Que CA)

49: Based on a review of cases in the Australian Digest (2d) and personal discussions with Mr.Peter Cashman, a research officer with the New South Wales Law Foundation, who has undertaken a study of mental health law cases (unpublished) in Australia and New Zealand. Some initial legal research conducted by this writer in Australia (September 1980) demonstrates that the issue of 'due process' in respect of involuntarily committed patients has been of concern in the past. In the State of Victoria, for example, Section 73 of the <u>Lunacy Statute, 1867</u> provided a facility for judicial involvement in the process of commitment. The section provided for a person in custody as a lunatic to be brought before a judge who would examine the person and order his discharge if the judge was satisfied that he was not insane. The operation of the Statute has also received judicial attention. In Re Roberts [1873] 4 AJR 5, for example, it was held that the process of review applies only to cases where the lunatic is confined at the instance of private persons and not where committed by justices for public safety.

50: Commenting in relation to Administrative Law, Reid has this to say:

> "...it is clear that administrative law in Canada today is in a sorry state. No proof of this is needed beyond the judgements themselves: every chapter of (Administrative Law and Practice) reveals contradictions on virtually every issue..."(1971:461)

The situation is no better in relation to mental health law.

51: In the Canadian context this has been termed the 'right to inviolability'. As Somerville notes, in the case of an 'incompetent' person;

> " (t)he major problem arises with regard to procuring 'informed' consent,...consent which...there is a duty to obtain in order to justify contravening the right to inviolability of the person. The dilemma can be stated interrogatively: in what circumstances is apparent consent not consent because of the disability of the patient, and when can someone, other than the person himself validly allow another... to contravene an incompetent's right to inviolability? The answers whether in fact, in law, or in ethics are not clear..."(op cit:68)

52: For example, in the legal aid context, see R v Ewing and Kearney [1974] 5 WWR 232. Controls on treatment modalities have also received a similar fate. In R v Hatchwell [1974] 1 WWR 307 (BCCA) and R v Buckler [1970] 2 OR 614 (OPC), attempts to have certain treatments ruled "cruel and unusual" were unsuccessful despite the fact that a United States court had so ruled on an identical treatment practice. Draper and Williamson(1976) in a study of, *inter alia*, the impact of the Bills of Rights on mental health issues indicate how 51 separate items of federal legislation and 83 items of Alberta provincial legislation (ranging from the *Human Tissue Gift Act 1973* to the *Libraries Act 1970*) limit the rights of, or make exceptions in relation to, mentally disordered persons, *vis-a-vis* Bills of Rights. Draper(1976a) has extended this analysis and concludes:

> "...the courts have taken a very conservative approach to the Canadian Bill of Rights and the Alberta Bill of Rights...More energy has been devoted to explaining why the Acts do not apply than to applying them. However, the judicial decisions have still left considerable scope for utilisation of the Bill of Rights to aid the mentally disordered person... The courts may baulk at such tradition-shattering steps as declaring the involuntary admission process to mental hospitals inoperative...yet, logically (they) are. Nowhere else in our law is such a casual attitude adopted regarding an individual's liberty, where the same persons may be "prosecutor, judge and jury" and the individual is given no opportunity to state his case to an impartial tribunal prior to incarceration... How the courts will employ the (Bills of Rights) in is largely a question for the future. One can merely hope that they will be more imaginative then they have been to date." (*op cit*:65-66)

Quite what the effect of current constitutional changes will be, especially on those provinces that do not have Bills of Rights, is unknown.

53: It is argued that the climate of opinion was set in Roe v Ministry of Health [1954] 2 QB 66; [1954] 2 WLR 915 926: in which Lord Denning stated:

> "But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken...we must insist on due care for the patient at every point but we must not condemn as negligence that which is only a misadventure."

This was followed, in Canada, in Halushka v University of Saskatchewan Hospital (1965) 52 WWR 608 (Sask CA). See also Ostrowski v Lotto (1973) 31 DLR (3d) 715 (SCC). However, note the English case, Hartnett v Fisher [1927] AC 573. Hoggett(1976) argues that following Hartnett, doctors and probably other mental health professionals owe a duty of care to the patient which is broken if they fail to take reasonable care in the circumstances, including the proper use of professional expertise. In addition, the Canadian case, Stadd v Alberton [1954] 2 DLR 328, appears to apply a more stringent duty in the case of mental health patients because of their propensity to injure themselves. See also the Australian case, Marshall v Watson (1970) 124 CLR 640, imposing omnibus protection.

54: (1954) 13 WWR 654 (Sask QB). Also X v Y [1970] Que CA 795, and Tanner v Norys [1979] 5 WWR 724. There does not appear to be a common policy in relation to the quantum of damages awarded in such cases.

55: For example, in Hall v Semple [1862] 176 ER 151 (QB), Crompton J. said,

> "...and I think that if a person assumes the duty of a medical man under this statute and signs a certificate of insanity which is untrue, without making proper examination or inquiries which the circumstances of the case would require from a medical man using proper care and skill in such a matter ...if he states that which is untrue and damage ensues to the party thereby, he is liable to an action."

In a later case, Everett v Griffiths [1920] 3 KB 163, Lord Atkin said,

> "Grievous as is the wrong of the unjust imprisonment of an alleged criminal, I apprehend that its colours fade into utter insignificance before the catastrophe of unjust imprisonment or of an unfounded finding of insanity...It is the effect on the mind sane, even if feeble, that knows itself wrongly adjudged unsound, that produces the most poignant suffering."

See also, Minchan v Beemer (1929) 37 OWN 52 (Ont HC) and Lumsden v Glidden (1920) 18 OWN 354 (Ont HC). Also note Hartnett v Fisher (supra): Hoggett(1976) argues that the latter judgement could be applied to a duty to take care in relation to correct admission procedures.

56: (1894) 10 TLR 543 (CA).

57: See note 55 supra.

58: [1973] SCR 673; (1973) 34 DLR (3d) (SCC).

59: (1978) 5 BCLR 347. The judgement in the case was based upon statutory interpretation (Mental Health Act SBC 1964 c.29, Section 30) rather than reference to legislatively established rights, per se. As such its generalisability is likely to be limited to cases involving similar legislation.

60: Actions brought by mental health patients are also restricted by the Rules of Supreme Court. The definition of a 'patient', viz, "...a person suffering or appearing to suffer from mental disorder," is wider than that used in the Mental Health Act, thereby effectively extending the limitation created by Section 141. See, Re S (F.G.) [1973] 1 WLR 178; [1973] 1 All ER 273 (Court of Protection).

61: [1975] 3 WLR 140; also as Poutney v Griffiths [1975] 2 All E R 881. See also Carter v Metropolitan Police Commissioner, The Times, 14th January 1975.

62: The incident was witnessed by a relative of the patient and the nurse was charged with and convicted of, common assault at the Bracknell Magistrates Court. As the rationale for Section

141 is to dissuade vexatious litigants, such a case demonstrates that it in fact operates to deter or confound any form of litigation, however just.

63: Jurisdiction does not extend to other Commonwealth countries (not being signatories to the European Convention on Human Rights). This remedy is being used in relation to three other matters involving the Mental Health Act, specifically in respect of the detention and recall of patients discharged under certain conditions, pursuant to Section 65. See, X v United Kingdom App No 6998/75; and Y and Z v United Kingdom App Nos 6870/75, 7099/75. See, Mental Disability Law Reporter, 1979a; Gostin & Rassaby,1980. For a complete discussion of the actual and potential role of the Commission in mental health matters see Muchlinski (1980) (esp. 102-112).

64: Possibly due to the then pending review of the legislation. The matter has been discussed in the British Government White Paper, 'A Review of the Mental Health Act, 1959,' but, because of a change of government in 1979 the paper has not yet found a legislative base. This issue was also discussed in a recent, unreported case before the English Court of Appeal: Ashingdane v Department of Health and Social Security, Court of Appeal, 18th February 1980. Ashingdane, a patient detained in Broadmoor under Section 65 of the Mental Health Act,1959 (special security) was deemed to no longer require treatment under special security conditions and a transfer to a local psychiatric hospital was arranged. However, such a transfer was opposed by the Confederation of Health Service Employees (the nursing union) who placed a ban on the admission of Section 65 patients. As a consequence, the transfer did not take place. This event alone raises interesting issues in relation to patients' rights (in this case the right to the least restrictive alternative) and the opposition that may arise at ward level. The plaintiff sought declarations against the respondent and others that they were acting in breach of statutory duty, and against the union alleging that they were causing the breaches. An injunction was also sought against the union action. The proceedings were stayed in the first instance under Section 141 and the court deliberated on the issue of whether or not there was substantial ground for the action. Although they found there was no ground for the action against the respondents, they did find grounds against the union and the stay was lifted in respect of that action alone. In a discussion of the case, Grosz (in Muchlinski,1980) argues that it indicates how Section 141 is invalid in light of Article 6 of the European Convention. A plaintiff is not only required to disclose his or her evidence at the outset, he or she must also demonstrate 'bad faith or want of reasonable care' on the part of the respondent. In effect, a pre-trial of the matter has to occur before the action can proceed.

65: For a discussion of the situation in Canada, see Chapter 6.

66: See Chapter 5 for a full discussion of the situation in Canada.

67: Briefly, the two fundamental rules are:

1. the rule against bias (nemo judex in causa sua) requiring that no person having an interest in the outcome of a case should be judge of it; and
2. the rule 'audi alteram partem' requiring that each party has notice of the case and is given an adequate opportunity to be heard.

68: This notion of a duty to act fairly, that is, observe the rudiments of natural justice for a limited purpose in the exercise of functions that are not analytically judicial but administrative, was first used by Parker L.C.J. in Re K(H)(an infant) [1967] 1 All ER 226 231. Since then the duty has been imposed on a number of advisory rather than decision-making bodies. See also Selvarajan v Race Relations Board [1976] 1 All ER 12, and Frazer v Mudge [1975] 3 All ER 78.

69: Unreported, QB Div Court, December 21st 1978.

70: This Board was formed in 1975 after an enquiry in 1972/3 into whether the procedures for the discharge and supervision of patients subject to special restrictions should be modified within the existing laws. The enquiry, chaired by Sir Carl Aarvold was held in conjunction with the Butler Committee who, at the time, were examining wider questions of law reform in the area. The Board consists of three members; a legal chairman, a forensic psychiatrist and a representative of the social work profession (see Gostin & Rassaby(1980), for a fuller discussion). It acts to provide a 'second opinion' in the case of specially identified patients who are recommended, by the review board or other authority, for discharge or transfer. Its proceedings are held in private and the patient is not permitted to be present, offer his or her opinion, or challenge the decisions made or 'evidence' received by the Board.

71: A MIND study indicated that between 1975 and 1978, 67 of the 72 recommendations made by the Board were accepted by the Home Secretary.

72: (1972) 10 CCC (2d)362 (F.C.T.D.).

73 : (1975) 25 CCC (2d) 81 (F.C.A.).

74: [1976] 1 SCR 453 (Sup. Crt. of Canada).

75: (1979) 46 CCC (2d) 342 (Ont. Div. Crt.).

76: (1980) 50 CCC (2d) 353 (Sup. Crt. Canada). See, also, two other Supreme Court cases: <u>Nicholson v Haldimand-Norfolk Regional Board of Com'rs of Police</u> [1979] 1 SCR 311; and <u>Attorney-General Canada v Inuit Tapirisat of Canada, et al.</u> (1980) 115 DLR (3d) 1.

77: (1981) 56 CCC (2d) 153 (Ontario Crt. of Appeal).

78: This ruling seems to be useful. However, the general guidelines offered by the court in relation to disclosure are rather vague and considerable discretion is still allowed to the Board.

79: Although the <u>Martineau</u> and <u>Re Abel</u> cases have begun the process of clarifying the status of review boards, considerable confusion still exists. In particular the most appropriate remedy for controlling their activities is still in doubt. As a consequence, there is a pressing need for the courts to clearly establish; i) that administrative tribunals are decision-making rather than purely advisory, bodies; and ii) that their decisions can be subjected to review by the courts particularly where boards abrogate the duty to act fairly and where the protection of the rules of natural justice is denied to appellants.

80: This issue is implicit in Endicott's recent discussion of the case (Endicott, 1980). He states that in April 1980 the Board of Review for New Brunswick produced a report on Bonnar.

> "It accepted the recommendations of the independent psychiatric assessments which dealt with Mr.Bonnar's need for an intensive programme of treatment and rehabilitation, but the Board refused to subscribe to the opinions of the two psychiatrists as to his fitness to stand trial or that his long period of confinement as a criminally dangerous person was the real cause of "his present debilitation."" (<u>op cit</u>: 2)

As the Board's recommendations included a programme of individual treatment and other special actions aimed at restoring Bonnar's health it is possible to suggest that the New Brunswick government may have delayed vacation of the Lieutenant Governor's Warrant and Bonnar's release until such time as the apparent, deleterious effects of institutionalisation had been considerably reduced. This would have effectively undermined any action in tort against the New Brunswick government. This possibility is supported by the fact that the Minister of Justice for the Province has indicated that even if Bonnar were declared to be fit to stand his trial the Crown could not proceed. The original reason for his detention is, therefore, no longer present although not because of

Bonnar's 'unfitness'. The recent release of Bonnar may now provide an opportunity for the proposed actions to proceed. At the time of writing no information in this regard is being released by the National Institute on Mental Retardation.

III. LEGAL AID DELIVERY AND MENTAL HEALTH: A FUSION OF INTERESTS

The somewhat dramatic and radical international developments in the provision and delivery of legal aid that have occurred in the last fifteen years have been recognised as probably the major change affecting the legal profession (so far) in the twentieth century (Abel-Smith, et al,1973). The genesis of legal aid and its attendant delivery modes (e.g. duty counsel schemes, community law centres, etc.) is a subject in its own right and has been dealt with elsewhere (Zander,1978; Johnson,1978; Haveman,1977; Cappelletti, et al,1975; Zemans,1978). Similarly the current problems with legal aid systems have also received attention. In particular, writers have examined the questionable impact of legal aid on the plight of the poor; the problem of community control or management; the trend towards government control and bureaucratisation; and the creation of lawyer-serving rather than client-serving structures.[1] (Zemans,1978; Johnson,1978; Morris & Stern,1976; Haveman,1977; Arthurs,1973; Handler, et al,1978; Zander,1978; Girth,1976). Some of these issues will be addressed in a limited fashion in following Chapters. Certain developments pertain directly to the main thrust of this thesis, particularly where they have involved an extension of legal aid delivery from its 'traditional' emphasis on the needs of the poor, to answering the legal needs of other disadvantaged groups.

Stimulated by various national enquiries into poverty in the 1960s and early 1970s (the formation of the Office of Economic Opportunity in the United States, the Senate Poverty Enquiry in Canada, and the Henderson Poverty Enquiry in Australia) and, particularly in the case of Canada, by the need to discharge certain international obligations,[2] the provision of legal aid allowing widespread access to legal services has been the goal of many organisations and agencies. The legal profession, governments and independent organisations have sought to finance and otherwise facilitate the rapid development and expansion of legal aid systems.

From its base as a mechanism for assisting or activating low income groups to improve their social, economic and psychological situations (Liffman,1978; Bothmann & Gordon,1979) the legal aid movement has turned to a wider client group as the concept of disadvantage has broadened. As a result, developments have occurred in relation to providing access to legal services for such groups as, prison inmates(Johnson,1978; Bachynsky, 1976; Conroy,1980 ; Brakel,1978; National Task Force,1979), the aged (Morris & Stern, 1976; Bothmann & Gordon,1979; Vancouver Community Legal Ass. Socty.,1973; Cass & Sackville,1975), children (Katz,1974; Knitzer,1976; Bachynsky,1976), native peoples (Rose,1975; Bachynsky,1976; Cowie,<u>et al</u>,1977; Legal Services Commission of B.C.,1976), migrants (Jakubowicz &

Buckley,1975), the deaf (Tharen & Fox,1979), and those living in isolated rural communities (Rose,1975; Bachynsky,1976; Cowie, et al,1977; National Task Force,1979; James,1973). More recently, attempts have been made to answer the legal needs of the 'middle market' (Lilly,1974), that is, people of 'moderate means' (Christensen,1970), through the creation of, inter alia, group prepaid and other legal insurance schemes (Wilson & Wydrzynski,1978; Marks, et al,1974; Murphy,1974; Pfennigstorf & Kimball,1977; Holmes,1977; Research & Resource Program,1979; Lilly,1978; Otto,1974; Canadian Bar Association,1973; Wydrzynski,1979).[3] There has also been a substantial movement, principally in the United States, Canada, Australia and England, towards answering the legal needs of clients of mental health systems, both those classified as 'ill' and those classified as 'retarded'. Such developments will, of course, be explored in depth in this thesis.

In many instances this process of expansion has involved a redirection of interest towards the goal of achieving 'equal justice for all'(Johnson,1978) and away from an emphasis on the poor, per se. However, developments have also uncovered groups of people who suffer double or multiple disadvantage; they are economically poor and also labouring under the weight of, for example, cultural dissonance, poor language skills, social stigma, lack of mobility, and residence in a closed or semi-closed institution. Such multiple disadvantage is most evident in the case of indigent mental health patients who, because of their low visibility, have a tendency to be the forgotten poor (Bothmann & Gordon, 1979). As a consequence of this general discovery the legal aid movement, originally conceived and developed as a specialist area of legal practice, began to generate its own 'in-house' specialisation, a process that has spawned the plethora of special legal services evident at this period of time in the evolution of legal aid.

Given that modern legal aid systems were developed from a platform of social action that would, it was hoped, change the situation surrounding the poor (notably by effecting law reform, encouraging preventive actions, and providing the poor with access to a resource that could introduce an element of power into and over, their lives) it is suprising that mental health issues did not hold more substantial appeal for the early legal aid practitioners. It could be argued that identifying the tendency for mental ill-health to arise as a consequence of poverty may have provided a more profound rationale for effecting social change than other professed reasons(e.g. the inequity of diverse income distribution). Similarly, the reverse situation, namely, demonstrating that poverty may occur as a result of mental-ill health (e.g. through loss of employment and/or institutionalisation) (Lamb & Zusman,1979) may have generated support for the mental health reform lobby. Mental ill-health, particularly those conditions that may be defined as 'chronic', seems to be a condition inducing greater suffering (particularly given ineffective mental health systems) than, for example, sub-standard housing, debts incurred through faulty family economics or oppressive conduct by social welfare administrators. As such, the legal aid movement, particularly in Commonwealth jurisdictions, missed an opportunity to reverse some of the community complacency identified by Liffman (1978) as a profound obstruction to the process of social reform.

In attempting to consider why this may have occurred it is clear that the problem does not lie with a lack of research linking mental ill-health and poverty. Historical analyses show a consistent pattern of government policies that induced a union of, in particular, the welfare and mental health systems, not only as a strategy for actually 'managing' the poor (Rothman, 1971) but also because poverty and mental ill-health were seen to be related (Talbott,1978; Szasz,1975)(the direction of the causal relationship, however, was not clear). Several major studies since 1950 have confirmed the latter relationship, notably the work undertaken by Hollingshead & Redlich (1958) and Srole, et al,(1978), in which it was found that in large metropolitan areas the poor were being treated for psychiatric disorders (notably the psychoses) more often and in greater numbers than all other socio-economic groups combined. Further the disorders were found to be more serious than those affecting other groups.

Replication studies (notably that conducted by Myers & Bean, 1968) and other research (Langner & Michael,1963) has served to a) overcome some of the methodological problems in the early studies, and b) confirm or elaborate upon the original findings. In addition it has demonstrated that poverty may be a significant cause of mental ill-health; more so than the reverse. Such studies have, however, been subjected to some criticism (Lamb & Zusman,1979). In an attempt to refine the relationship researchers have indicated that the stress of existing in the type of debilitating environment experienced by low income groups results in a decline in mental health (Riesman,et al,1964; Allen,1970; Langner & Michael,1963; Goodman,1973; Levi,1971; Wolff,1971; Barrett,et al ,1979; Mann,1970; President's Committee on Mental Retardation,1976) particularly where such environmental factors are aggravated by poor physiological and neurological development, and poor nutrition ((Allen,1970; Levi,1971). This argument is supported by the proponents of orthopsychiatry (Levitt & Rubenstein,1968) although criticised by others because of a lack of methodological rigour (Lamb & Zusman,1979). Further, in dealing with the corollary of these findings, research has established that "if the noxious and pathological aspects of the poverty environment are removed, the incidence of mental disorder (will) decrease."(Gottesfeld,1979:459) providing, not only further evidence of the relationship but also a recipe for resolution that seems to complement the professed objectives of the legal aid movement.

Despite the evidence presented by the research (particularly that detailed by Gottesfeld (Ibid)) little progress appears to have been made to redress the situation. As recent research indicates, the poor (particularly the chronic poor) are still over-represented in mental health institutions (Erbinger & Christie-Brown,1980)[4] and community health centres (Heiman,1980; Williams, et al, 1980). Whilst this might be due to the relative powerlessness of the poor (leading to a greater likelihood that they will be diagnosed as seriously ill(Pemberton,1979) and consequently housed in or referred to, state institutions (Waxman,1977)) and the use of the mental health system as an alternative to an ineffective welfare system (Szasz,1977; Rothman,1971; Ennis,1972; Ebringer & Christie-Brown, 1980) epidemiological research continues to confirm the relationship between low socio-economic status and mental ill-health established by the original studies (Dean & James,1980).

Whether poverty causes mental ill-health or mental ill-health causes poverty, it is clear that the interests of both the mental health and legal aid movements close around mental health patients and their unmet legal needs (Martindale & Martindale,1973). This has been most trenchantly summarised by Friedman (1977) in an address to a United States Senate

Sub-Committee.

> "Involuntarily institutionalised persons have little or no access to lawyers because of their total confinement; they are typically indigent and without resources to pay for counsel; the law often considers them incompetent to bring suits in their own name. Most do not know or comprehend their legal right to resist encroachment on their constitutional domain. They are peculiarly subject to intimidation, harassment and retaliation from custodians when they do complain. Rarely will state agencies who are part of the same 'executive family' as their custodians bring suit on their behalf. Realistically they must depend for relief on legal service poverty lawyers..."(op cit:813)

Lawyers associated with the mental health movement have been energetic, if not (in Commonwealth jurisdictions) completely effective, particularly in the area of pursuing patients' rights. This, as Brooks indicates (1974), has involved the development of new legal concepts and a re-examination of older doctrine (for example, the notion of due process). Similarly, the right to counsel in the case of involuntarily committed patients, which may be considered a 'first generation' issue, developed, as a 'second generation' issue, into the right to have court-appointed counsel in the case of indigent patients. In this context mental health advocates made clear use of precedents established by the legal aid movement (Gideon v Wainwright;[5] Re Gault[6]). More recently this has led, in the United States, to the creation of legislation establishing and funding patient advocacy services[7] (Mental Disability Law Reporter, 1977, 1977a, 1978), the production of 'model' legislation for future enactments in the area of patients' advocacy (Mental Disability Law Reporter,1977a), and an examination of the potential role that could be played by lay advocates and para-legals (Cohen, in Kindred, et al,1977; Mental Disability Law Reporter,1977a).

It thus appears that, particularly in the United States, there was an early recognition of the potential for a fusion of mental health law and legal aid interests. Certainly, as some writers have indicated, the legal aid movement foresaw the possibility both theoretically (Johnson,1978) and as a result of encountering cases involving indigent mental health patients in need of legal assistance (Abel-Smith,et al,1973; National Conference,1965; Wald & Friedman,1978; Bothmann & Gordon,1979; Brieland & Lemmon,1977; Morris & Stern,1976; Vancouver Community Legal Ass. Socty.,1973). However this specialist area of legal need appears to go unmentioned in both key legal aid research projects (e.g. Cass & Sackville,1975; Curran,1977; Messier, 1978) and the proceedings of legal aid conferences (e.g. Rose,1975; Bachynsky,1976). On the other hand writers, in the mental health law and other areas, seemed to be more alert to the value of providing patients with unlimited access to legal services (Kittrie,1971; Brakel & Rock,1971; Dershowitz,1977; Stone,1975; Polier,1968; Farmer,1967; Halpern,in Burris, 1969; Cohen, in Kindred,et al,1977; Powell,1978; Ennis & Siegel,1973). It has to be noted, however, that such writers were primarily concerned with civil rights issues rather than the complete spectrum of legal need.[8] As a result, it is conceivable that in the functional confusion arising as a consequence of the rapid growth of two dynamic movements (mental health law and legal aid) a more substantial formalisation of the relationship was by-passed in favour of pressing concerns associated with actually rendering their respective organisations more viable and concrete. Although they were (and are) two organisations sharing an underlying philosophy that encompasses the drive for social reform through legal action, it is a drive involving different emphases. On the one hand, the mental health movement was concerned specifically with the issue of rights, as evidenced by litigation associated with the group. On the other hand, the legal aid movement, whilst obviously not dismissing civil rights matters, was specifically concerned with a wider definition of legal need related to, inter alia, answering both immediate and individual needs and the needs of the poor as a group. Herein, it is argued, lies the dilemma posed for the legal aid movement by the contradiction between individual client needs and group needs; a dilemma that has never been resolved in legal aid delivery and which leads to critiques that point to the limited, 'band-aid', effect of a legal aid movement that does not place enough emphasis on reformative actions (Bothmann & Gordon, 1979). In this respect, a brief examination of the broader relationship between civil rights issues generally and the problems confronted by legal aid may be useful.

In both Commonwealth and United States jurisdictions (where needs have tended to be more clearly defined as 'rights'), there appears to have always been a ready recognition that civil rights and the practice of poverty law (the accumulated body of law and legal expertise associated with the legal aid movement) have a distinct mutuality. It is a mutuality that is most apparent when the reformative aspects of poverty law are taken into consideration (notably, establishing welfare rights) and if access to legal services, as well as 'equal justice', are considered to be 'civil rights'. However, the lack of an early and substantial fusion of interests may lie with problems associated with poverty law itself, for it seems that practitioners, particularly in Commonwealth jurisdictions, concentrated on matters of immediate importance to individual clients rather than broader, reformative actions. Whilst this tendency may lie with an initial failure to properly address the question, "what type of reform is likely to alleviate poverty?" resulting in a confusion of political ideologies and social work objectives, a problem may also lie with the extensive and ambitious nature of poverty law; that is, its all encompassing character and the difficulties experienced in developing a new area of legal specialisation.

As I have argued elsewhere (Bothmann & Gordon,1979), aside from its reformative aspects, there are "two elements in poverty law. One involves legal problems encountered by all (socio-economic) groups but which are exacerbated by the social conditions of the poor; the other involving legal problems only encountered by the group"(op cit:16). The problems of the poor coincide with existing categories of legal specialisation (matrimonial, crime, landlord and tenant, etc.) but at the same time there is a need to develop an expertise in these areas that takes into account the special circumstances affecting poor clients. In addition, poverty law has to develop a specialist area of its own - 'social welfare law' - to deal with matters that will only be encountered by low income clients.

In this respect, social welfare law serves to advance the interests of the poor by treating welfare benefits as their 'property' rights. As Reich has argued (1964), the rise of government largess has produced a situation where many social groups have become increasingly dependent on government for their income. This situation extends beyond that affecting disadvantaged groups many of whom derive their income from government welfare benefits. Through the distribution of contracts, franchises, and subsidies many commercial enterprises are also significantly dependent upon government for economic support. Just as these groups have access to existing bodies of law and legal practice to protect their interests so those receiving benefits also need access to law to protect their interests and to re-interpret 'privileges' as 'rights'. Poverty law, but more particularly 'social welfare law', can be seen to provide such protection. Law, argues Reich (1964), is built on the concept of property and is relevant and effective for those who are recognised as having property. By re-defining this concept in a context that acknowledges the <u>broad</u> growth and impact of government largess, the notion of 'new property' will serve to place the situation faced by the poor in a different light. They will be seen to have property rights and, as a corollary, be able to use law as a mechanism for protecting such rights.

Building on this thesis, Mayhew & Reiss (1969) have argued that where individuals have property they will make greater use of legal resources. Where the poor do not use such resources it is for reasons other than simple economic constraint. "The poor have fewer legal problems only in the narrow sense that they have fewer problems that the legal profession habitually serves" (<u>op</u> <u>cit</u>:317). Prior to the emergence of poverty law, the legal profession was organised to serve clients with property and other specific problems. The legal aid/poverty law movement serves to alter this situation by acknowledging that "rights to welfare benefits, job and retirement rights, and civil rights will only be adequately protected when lawyers come to see them as property rights"(<u>op</u> <u>cit</u>: 317). The notion of 'new property' has to be recognised and entrenched and this process has to be reflected in the 'production' of lawyers who will specialise in serving the 'new property' interests of the poor. Poverty law thus automatically includes a reformative element, little attention (in a judicial and legislative sense) having been paid to the issues involved in this area of sub-specialisation prior to its emergence.[9]

That poverty law has emerged and been established as a *bona fide* area of legal specialisation cannot be doubted. Indeed a positive mark of its respectability is the presence (since 1972) of the Commercial Clearing House, Poverty Law Reporter. This and other materials on or discussions of, the topic in the United States (Jarmel,1972; Handler, *et al*,1978; Girth,1976; Brudno,1976; Berney, *et al*,1975; Practising Law Institute, 1970), England (Byles & Morris,1977; Smith & Hoath,1975; Legal Action Group, 1973), Australia (Neal,1978; Bothmann & Gordon,1979); Canada (Legal Aid Committee of Ontario,1972; Saskatchewan Community Legal Services Cmmsn.,1975; Cotler & Marx,1975; Cowie,1974) and South Africa (Gross, 1977) demonstrate a seemingly universal and consistent pattern of work between and within different jursidictions.

Although also seen as a 'category of action', rather than just a 'category of law' (Bothmann & Gordon,1979:18) in the main practitioners have concentrated on conventional service delivery handling casework in the following areas: criminal law, accommodation and housing, worker's compensation or industrial injury benefit, employment and wages, matrimonial and ancilliary matters, personal injury and motor car accidents, consumer and debt matters, immigration, complaints against authorities, and other general matters (e.g. making a Will, Probate, etc.). The sub-specialist area (social welfare law) is equated with the pursuit of welfare rights and, as I have indicated, in this sense it can be seen to be involved with a specific 'civil rights' issue. Broadly speaking, practice in this area "can involve pursuing present (welfare) entitlements for clients wrongly refused relief as well as pressing for changes to regulations setting out criteria for the granting of such relief. As important, it can involve pressuring relevant bureaucracies to be less secretive about the criteria they use to determine eligibility" (Bothmann & Gordon,1979:84). Practitioners have to develop expertise in relation to the relevant legislation and, where permitted, represent clients making use of administrative appeals tribunals or their equivalent. As some writers have indicated this can involve, especially in Commonwealth jurisdictions, complex legal activity in an area bereft of precedent and expertise (Smith & Hoath,1975; Bothmann & Gordon,1979; Neal,1978; Byles & Morris, 1977).

As a 'category of action' poverty law in practice has been, and is, faced with additional complex demands. In discharging this aspect of its mandate, it is concerned with social and legal reform and the closely related notion of 'community development'; a process that is tied to attempts to collapse both the structural and psychological barriers to poverty resolution (Liffman,1978; Bothmann & Gordon,1979). This type of 'action' can involve encouraging community self-help in such areas as economics (establishing business ventures and entrepreneurial co-operatives to help low income people to 'work' their way out of poverty and credit co-operatives to provide access to money); housing (establishing housing co-operatives or organising tenants as a 'union' in opposition to housing monopolies); health care (organising improved facilities in a community); and politics (encouraging group involvement in the management of local communities and agencies such as community law centres)(Kirkpatrick in Rose,1975; Bachynsky,1976), an idea that has aroused considerable debate (Stumpf,1975; Leask,1974; Morris & Stern,1976; Arthurs,1973; Bothmann & Gordon,1979; Parkdale Comm Legal Services,1979; Bachynsky,1976). As Kane has pointed out, "(i)f legal aid is ever to be seen as part of the solution to poverty, it must begin to develop the resources that cannot only act as legislative advocates but also assist in the economic development of the community" (in Bachynsky,1976:138); a proposition that involves an integrated approach to the structural problems affecting the poor by combining the case-work and reformative aspects of poverty law practice. Whilst such an approach can only be acknowledged as a vital aspect of poverty law, it effectively raised and still raises major problems for the overstretched resources of the legal aid movement as it attempted/attempts to maximise its coverage.

The embryonic nature of poverty law, the need to develop both expertise and precedent in the area, the lack of any clear direction in which to steer reformative actions, and the problems associated with the attempt to give effect to the notion of community development may, therefore, have acted as a restraint on a more substantial union of legal aid and civil rights interests and on the reformative actions of legal aid workers. To these factors can be added two other problems that arose for the legal aid movement; i) the introduction of legislation and other government actions designed to restrain reformative actions by legal aid workers perceived to be 'radical';[10] and ii) the overwhelming demands of clients who turned to legal aid for assistance in a greater volume than was originally expected (see, e.g., Disney, et al,1977; Friedman,1977; Cappelletti,et al,1975). In short, in this respect, legal aid workers had all their energies directed towards i) protecting themselves from certain government efforts to restrain or channel their activities, and ii) dealing with the case-work volume. It is argued that this left little time for broader civil rights issues, for substantial reformative work and for the pursuit of the interests of any single group of disadvantaged people, for example mental health patients, especially where such a group may already have been seen to be served by a group of legal workers (e.g. mental health lawyers in the United States).

To these restraining factors can be added, in the case of Commonwealth jurisdictions, the absence of any facility for or tradition in relation to, the pursuit of civil rights and the absence of any substantial mechanism for undertaking reformative legal action (e.g. through class actions).[11] As Gall has noted (1977), in the case of Canada (and notwithstanding the restraining effect of the doctrine of parliamentary supremacy) the law of civil liberties can be seen to be in its infancy. Given that it took the American judiciary almost two hundred years to develop their law of civil liberties, "we are perhaps expecting too much to happen too quickly" (op cit:75). The same sentiment could, justly, be applied in answer to the criticism that the legal aid movement was tardy in meeting the legal needs of mental health patients. This is particularly so, given the confluence of restraining factors confronting the legal aid movement and the substantial efforts now being made to redress the situation.

At present the provision of legal services for mental health patients, both those classified as 'ill' and those classified as 'retarded' or 'developmentally disabled', is most advanced in the United States (Curran,1978; Weisberg,1979). Although the development of these services has tended to dominate the discussion, description and analysis of the growth and practise of such legal advocacy, a significant amount of activity has been occurring in some major Commonwealth countries, notably Canada, England and Australia. Indeed it appears that, of all Commonwealth countries, Canada has experienced the most substantial developments and serves to provide something of a blue-print for other countries following the British legal tradition.[12]

This is not to suggest that the history of legal services for mental health patients, in the United States, is particularly old. Writing in 1977, Brakel observed,

> "...currently, with the exception of experiments in a few jurisdictions, legal services of any kind to institutionalised people, let alone the kind that proceeds from continuous presence at and knowledge about the institutions, is both spotty and sporadic. Public defender offices or legal aid-like organisations in some states are assigned responsibility for providing representation in commitments, but these already generally overloaded offices have difficulty meeting such special burdens."(1977:474-475)

This complaint was echoed by Friedman, the managing attorney of the Mental Health Law Project in Washington, D.C., who, in addressing a U.S. Senate Sub-Committee in 1977, stressed the inadequacy of advocacy resources, at that time (Friedman,1977).

A possible exception to this situation comes by way of the New York Mental Health Information Service. Established by legislation[13] in 1964, it was probably the first organised representation service for patients in the United States

(Gupta,1971; Kumasaka & Gupta,1972; Columbia Law Review:Note, 1967; Andalman & Chambers, 1974; Stone,1975) beyond that loosely provided by public defender offices (see, e.g., Cohen,1966). In addition at least one legal aid organisation (The Free Legal Aid Society of Cleveland, Ohio) established legal services in several state institutions in the early 1970s (Strand,1972), as did the University of Wisconsin Law School (Dickey & Remington,1976), and the University of Virginia Law School (Brakel,1978). Further, as Johnson & Aanes (1974) and Jansen & Krause (1974) report, patients' advocate offices were opened in Minnesota state hospitals in mid 1972. These projects were staffed by social workers rather than lawyers and appeared to be modelled on the concept of the hospital 'ombudsman' that began to find favour in the late 1960s (Ishiyama & MacCulley,1969). Such schemes were best exemplified by the short-lived lawyer-ombudsman experiment that operated between 1969 and 1970 at St. Elizabeth's Hospital in Washington, D.C. (Broderick,1973) but were not 'legal services' in the conventional sense. In New Jersey, a division of the Department of Public Advocacy involved only in mental health advocacy, was established in the summer of 1974 (Wilson, et al, in Kopolow & Bloom,1977) and, in Michigan, in the same year, a system of 'Rights Advisors' (again not strictly a legal service), was established within the Michigan Department of Mental Health (Coye, in Kopolow & Bloom,1977; Wilson, et al, in Kopolow & Bloom,1977).

Although these developments and the parallel activities of patient, parent and relative organisations in a loose alliance with civil rights lawyers (notably the New York Civil Liberties Union), were of great significance (see Ennis,1972; Ennis, et al,1974; Ennis & Siegel,1973; Wald & Friedman,1978) the major impetus appears to have come from the American Bar Association's Commission on the Mentally Disabled in 1976 (Brakel,1978). With a grant from a Foundation, the Commission set up eleven advocacy experiments between 1976 and 1977 in different parts of the United States (Georgia, California, Colorado, Illinois, New York, Nebraska, New Jersey, Vermont, North Carolina, Missouri and Pennsylvania). Employing different delivery modes these experiments have tended to provide the basis for subsequent legal services for the mentally ill even though it appears that the experiments have only been subjected to limited evaluation(see e.g. Steadman & Brooks,1977; Garcia,1977). Similarly, those organisations operating outside of the Commission's experiments do not appear to have been swift to assess their operations (see, however, Coye & Clifford,1978; Coye, in Kopolow & Bloom,1977; Van-Ness & Perlin, in Kopolow & Bloom,1977; Swan & Dipert, 1979). Nevertheless both some of the experiments undertaken by the Commission and some of those organised by other agencies, still appear to be in operation, suggesting that evaluations may be forthcoming in due course.

As discussed in Chapter 2, a further significant impetus came from government sources, notably the President's Committee on Mental Retardation (1976), and a Senate Sub-Committee on the civil rights of institutionalised persons (1977). The former recommended the establishment of, <u>inter alia</u>, "a nationwide system of public legal advocacy services" (<u>Ibid</u>:65) to give effect to specific rights adopted by the General Assembly of the United Nations in 1972 (Declaration of General and Specific Rights of the Mentally Handicapped), as enshrined in the federal <u>Developmentally Disabled Assistance and Bill of Rights Act</u> (P.L. 94-103) passed by the United States Congress in 1975: This Act can, in itself, be seen to be an important source of encouragement given that it included a directive (yet to be proclaimed) that in order to qualify for federal funding the states should have established, by October, 1977, an advocacy system to protect and enforce the rights of the developmentally disabled (Powell,1978)(also see, Scallett,1980; Weisberg, 1979).[14] Whilst such an impetus was primarily to the benefit of the developmentally disabled as opposed to the mentally ill, the Senate Sub-Committee's hearings had a more general application.

In what the Committee described as, "an attempt to deal with the last great frontier of civil rights litigation", they sought to establish legislation that would provide an effective and centralised mechanism for the protection of citizens' rights. In particular, such legislation was to formalise and strengthen the operations of the federal Attorney-General when bringing actions against states to protect rights. In this respect, they clearly extended their mandate to encompass all institutionalised people. The Committee heard evidence from a wide range of concerned individuals, including those involved in mental health advocacy (Garcia,1977; Friedman,1977). As a result, the difficulties confronting existing special legal services for the mentally ill were effectively exposed and, it appears, attracted both considerable attention and sympathy (U.S. Senate Sub-Committee,1977).

In all probability, however, it was the promise of fiscal support in relation to the developmentally disabled that stimulated the emergence of legal advocacy services; a proposition that seems to be supported by a closer examination of the types of services that exist at the moment.

Although difficult to determine with precision there now appear to be 139 legal services for mental health patients in the United States. All states, Washington D.C. and the territories of the Virgin Islands, Guam and Puerto Rico have some form of legal service or legal advocacy although national coverage is only complete in the case of the developmentally disabled. Table I provides a breakdown of the 139 agencies indicating the type of organising body and the main emphasis (that is, the type of client group served) of the services.[15]

TABLE I

NUMBER AND DISTRIBUTION OF LEGAL ADVOCACY SERVICES FOR MENTAL HEALTH PATIENTS AND THE DEVELOPMENTALLY DISABLED: UNITED STATES OF AMERICA 1979-1980

	MAIN EMPHASIS		
Organizing Agency	Developmentally Disabled	Mentally Ill	Both
State or Territory Dev.Dis.Advocacy Program	40		
Other Dev.Dis. Advocacy Agency	26		
Community Legal Service or Legal Aid Society Dev. Dis. Advocacy Program	5		
Independent Advocacy Program for Mentally Ill and Dev.Dis.			3
State Public Advocate (Mental Health Advocacy)		5	
Bar Association Mental Health Advocacy Project		5	
Public Defenders Office: Mental Health Division		3	
Legal Aid Society Legal Advocacy/Mental Health Law Project		6	
University Law School Mental Health Law Project		5	

TABLE I (continued)

Organizing Agency	MAIN EMPHASIS Developmentally Disabled	Mentally Ill	Both
State Supreme Court Mental Health Law Program		6	
Community Legal Services; Mental Patients Advocacy Project		8	
Civil Rights or Public Interest Law Agency			6
Advocacy Program for Generally Handicapped or Disabled Persons (e.g. Deaf, Aged, War Veterans)			14
Miscellaneous Agencies (Affiliation or Scope is unclear)	1		6
TOTAL	72	38	29

It will be noted that 72 of the 139 services are primarily for the developmentally disabled and that 40 are provided by agencies organised by a state or territory government in response to the promise of federal government fiscal support. Private agencies organise 26 advocacy services whilst legal aid bodies have established five special legal services for the developmentally disabled as an annex project to their main delivery programme.[16] The remaining 67 advocacy services assist either the mentally ill or both the mentally ill and the developmentally disabled. Of the latter, six are agencies concerned generally with civil rights or public interest law for many groups beside the mentally ill but also include the Mental Health Law Project in Washington, D.C., and the Mental Health Law Project in New York (a branch of the New York Civil Liberties Union) both of which are well known for their long standing concern with patients' rights.[17] Whilst a further three agencies serving both the mentally ill and the developmentally disabled are providing direct advocacy services (Mississippi Mental Health Project, Missouri Institutional Law Project and the North Carolina Protection and Advocacy System), fourteen are involved in direct advocacy for a broader client group, namely all handicapped or disabled persons (e.g. the deaf, the aged and war veterans as well as the developmentally disabled).

Only 38 of the 139 advocacy services are, therefore, providing legal services specifically for the mentally ill, a closer examination of these services demonstrating the presence of close ties with the legal aid movement not found in relation to services for the developmentally disabled. Eight services are mental patients' advocacy projects established by conventional community legal services as an adjunct to their broader delivery system. Western Massachusets Legal Services operate a well entrenched project in the Northampton State Hospital (see Schwartz & Stern,1977), whilst, in the State of Washington, Evergreen Legal Services have an equally well organised institutional legal services project affecting five centres;[18] an additional project in the same state is operated by the Spokane Legal Services Centre. Institutions in Minneapolis are served by Central Minnesota Legal Services. In addition to services in the latter category, five university law schools and six legal aid societies have organised mental health law projects involving direct patient services,[19] whilst in three locations (Los Angeles County, Washington, D.C., and Baltimore, Maryland) legal services are provided by a special mental health division of the Public Defender's Office. Three legal services are provided directly by the American Bar Association as a continuation of their initial, experimental mental health advocacy projects established in 1977 (Haverton, Norristown and Wernersville State Hospitals in Pennsylvania) and a further two projects are operated by County Bar Associations in California (Los Angeles County and Santa Clara County).

Probably the most well known legal service for the mentally ill is that provided by the New York Mental Health Information Service, an agency controlled by the New York State Supreme Court. This approach appears to have been followed, in part, by the Massachusetts State Supreme Court which has established a mental health legal advisors program covering various state institutions. From its central office in Boston, the program administers branches in Belchertown State School and the Danvers, Fernold and Worcester State Hospitals. Collectively these agencies in New York and Massachusetts account for six legal services.

Finally it is necessary to consider five other services provided, through government, by way of the recently developed concept of a Public Advocate. As Sullivan reports (1979), the first Public Advocate in the United States began work in New Jersey in 1974 with terms of reference similar to those associated with Ombudsmen in other countries. A significant difference lies in the fact that, at least in New Jersey, the Public Advocate has a responsibility for administering the Public Defender's Office and can undertake actions on behalf of any group or in the public interest; in this respect it is a more powerful organisation than any Ombudsman's office (Weeks,1978). The New Jersey Department of the Public Advocate has established three branch offices dealing with mental health issues (in Camden, Newark and Trenton); a system followed in

Kentucky (Office of the Public Advocate, Frankfort) and in Rhode Island (Office of the Mental Health Advocate, Cranston).

It is thus possible to see, in United States jurisdictions, something of a practical fusion of mental health law and legal aid interests, particularly in relation to patients classified as 'mentally ill'. Indeed, as Wald & Friedman note (1978), the level of funding and the priorities of the Legal Service Corporation will have a considerable influence on developments in the area. However, there is, by no means, an over-reliance on legal aid organisations nor is it apparent that such agencies have been the only source of encouragement in relation to developing patients' legal services. A major impetus appears to have come from, a) legal profession bodies funding various experiments (e.g. the American Bar Association); b) agencies established by the courts (e.g. the New York Mental Health Information Service); and c) state agencies directed by court orders (see, for example, <u>Davis v Baylor</u>[20]) or established by legislation[21] to organise and operate special patient advocacy services (for all clients of the mental health system) independent of or as an adjunct to, public defender systems. This contrasts, I would argue, with the situation prevailing in Commonwealth jurisdictions, particularly in Canada and Australia.

Given that many mental health patients were and are, also economically poor, it will be apparent that the tenets of poverty law and legal aid apply in their case. Indeed the growth of legal services for mental health patients, in Commonwealth jurisdictions, can be seen to be tied more closely to legal aid structures than is the case in the United States; structures that emerged in the different jursidictions to give effect to a philosophy of allowing 'equal justice for all'. As I have argued elsewhere, in relation to Commonwealth jurisdictions (Gordon,1981), "the development of legal aid systems has provided financial, organisational and conceptual support and direction (for mental patients' legal services), giving i) an impetus to the few pre-existing but *ad hoc* legal services (notably those available through patients' organisations); ii) a selection of different legal service delivery modes; and iii) personnel interested in uncovering and answering the legal needs of disadvantaged groups such as mental health patients."

At the same time such systems have also tended to determine the emphasis, approach and, to some extent, the impact of existing services, notably the physical delivery mode, the delivery style, and the delivery objectives. Legal aid systems, which are affected by prevailing government or legal profession policies, have provided a framework in relation to coverage (the types of cases that will be undertaken), client eligibility (in general, only patients with limited incomes are able to benefit from legal aid schemes) and remuneration for legal workers. As such they have also tended to restrain the work of legal services in both a procedural and economic sense.

This is not to suggest that, in Commonwealth jurisdictions, legal aid systems have been the only source of impetus for mental patients' legal services. Indeed, in England, the dominant source of legal assistance has been in the hands of the Legal Department of the National Association for Mental Health (MIND), a division of an agency that has long acted as a 'consumer group' for mental health patients. Although, as Gostin reports (1977)(see also Bacon,1975), the British, National Council for Civil Liberties, had provided a limited scheme of volunteer representation for patients appearing before review tribunals since 1959 it is only since 1979 that the beginnings of an organised representation service, through MIND, has been in operation (Gostin & Rassaby,1980). However, this service is still tied to the English legal aid 'system' and its attendant financial and organisational weaknesses (op cit). Similarly, in Canada, the Canadian Mental Health Association, another 'consumer group', played and still plays a significant role in providing, inter alia, patient representation before review boards and their equivalent (notably in Ontario) (Standing Social Development Committee,1978; Swadron & Sullivan,1973). In addition, the National Legal Resources Service (formed in 1978) of the National Institute on Mental Retardation and the more recently established (1980) Advocacy Resource Centre for the Handicapped (ARCH), in Toronto, have been active in pursuing the interests of, in particular, the developmentally disabled. Notwithstanding the impact of these agencies, however, it is apparent that formal legal aid systems have been the principal driving force in developing patients' legal services. An examination of the emergence of such services, in Commonwealth jurisdictions, should serve to establish this point.

It appears that, in Canada, the early 1970s saw several initial developments in providing legal services for patients. In 1972, in British Columbia, a loose amalgamation of interested parties (a psychiatric social worker, law students and lawyers involved in the then evolving legal aid movement) began a limited legal advocacy project for patients in a large psychiatric institution.[22] This project developed, at first under the auspices of the B.C. Legal Aid Society and then under the auspices of the Vancouver Community Legal Assistance Society (V.C.L.A.S.) with assistance from the Donner Foundation (Vancover Community Legal Assistance Society, 1973). In September 1977, with federal government support, V.C.L.A.S. expanded the project and established the Mental Patients' Advocate Project in Riverview Hospital, Coquitlam, B.C. However, federal funding for this project was withdrawn in September 1980 and although the B.C. Mental Patients' Association provided interim assistance, the Project had to suspend <u>full</u> operations in January 1981.[23]

This programme was, and is, supplemented by the provincial Legal Services Society, who in 1974 organised a patients' appointee project to assist those appearing before review panels established under the Mental Health Act (Legal Aid Society,1977). A panel of interested lawyers has been developed and, on receipt of a request from either a patient or an hospital social worker, the Legal Services Society refer the matter to a private practitioner on the panel, the cost of representation being born by the provincial mental health authority.[24]

Evidence of early developments can also be found in Nova Scotia, Ontario and Manitoba. In 1973, in response to increased requests for assistance from mental health patients, the Dalhousie Legal Aid Service conducted research into the legal needs of those persons in Metropolitan Halifax/Dartmouth who were confined in mental institutions, or who were developmentally disabled (Dalhousie Legal Aid Service,1973). Their report called for the use of a specially trained para-legal to deal with mental health issues generally although this idea has yet to be operationalised in Nova Scotia.[25]

In the same year, in Ontario, a sub-committee of the provincial Legal Aid Committee was appointed to examine a brief from the Psychiatric Hospital Patients Welfare Association (a province-wide, patients' group) concerning matters related to safeguarding the civil rights of involuntarily committed patients (Legal Aid Committee of Ontario,1973). As a result, a special training programme was organised to prepare volunteer duty counsel, working under the provincial 'judicare' system, for an experiment in providing legal assistance to patients in provincial psychiatric hospitals. Because of difficulties posed by the need for counsel to have access to patients' records and the fear that this would breach hospital/patient confidentiality[26] the commencement of the planned, one year project was delayed (Legal Aid Committee of Ontario, 1974). Finally in early 1975, duty counsel appeared in 14 Ontario psychiatric institutions (including three for the 'mentally retarded') and, on a regular basis, attempted to assist patients with legal problems (Legal Aid Committee,1975; Schachter & Sheppard,1975). This programme is still in operation.[27]

Whilst this system was being developed and operationalised an independent, patients' ombudsman experiment began at the Lakeshore Psychiatric Hospital in Toronto. The scheme, which was not a 'legal service' in the conventional sense, ran from May 1973 to October 1974 and, as Dobson & Hansen report (1976) was designed to provide a mechanism for protecting patients' rights in an essentially mediatory context.

> "The ombudsman was to promote patients' awareness of their legal status and appeal avenues during hospitalisation. When patients felt they were being treated unfairly by the hospital's bureaucracy (the ombudsman) was available to the patient to investigate. (He) was to establish an overview on patients' rights and recommend changes in policy and practice where

> patients' interests were unduly compromised." (op cit:492)

In addition, the ombudsman sought to educate hospital staff in an attempt to prevent many of the problems that were found to be arising. In general the scheme appeared to be successful - particularly as the ombudsman sought to consider the 'rights' of all the parties in a dispute. In doing so, he attempted to avoid the polarisation associated with a partisan approach to protecting patients' rights. The reasons for not continuing the scheme are unclear although the final operationalisation of the Legal Aid Committee duty counsel scheme was obviously influential.

At the same time as the duty counsel scheme was being developed, an independent legal clinic opened at the York-Finch General Hospital in Toronto. Organised by the mental health unit at the hospital and several private practitioners, the clinic appears to have commenced operations in 1974 in response to perceived patients' needs in the more conventional legal aid/poverty law areas (Monahan,1975). Heralded as a laudable example of an interdisciplinary approach to the needs of mental health patients (op cit:319), the scheme is still in operation although it is now functioning as a location for summary advice and legal aid applications (funded by the Ontario Legal Aid Plan) rather than as an independent community-based legal clinic (Ontario Legal Aid Plan, 1979).[28] The year 1974 also saw the commencement of a patients' legal service at the Queen Street Mental Health Centre in Toronto. Organised by Toronto Community Legal Assistance Services (an agency established by the Faculty of Law, University of Toronto and funded by the Ontario Legal Aid Plan) this legal service was designed as an annex to a conventional community legal aid facility answering unmet legal needs in a full range of areas. Apparently due to a lack of interest on the part of patients and some conflict between legal aid and mental health centre staff, the project closed down in 1980.[29]

It appears that, in Manitoba, the provision of legal services to mental health patients (particularly the mentally ill) was of interest to the provincial Legal Aid Services Society in 1973. As Bolton, _et al_, report (1975), in that year, "preliminary discussions were conducted by the Society with the Director of Psychiatric Services and the Medical Director of Selkirk and Brandon Mental Health Centres"(_op cit_:1), following which a committee was formed to investigate the issue. As a result of their report (Bolton, _et al_,1975) a duty counsel scheme involving staff lawyers from community legal services offices, commenced operations in January 1975 (_op cit_; Legal Aid Services Society of Manitoba,1975,1976) and is still in effect, providing informal advice and counselling to patients at three centres in the province.[30]

The impetus created by such innovations in the early 1970s generated other, later responses on the part of Canadian legal aid bodies. In Alberta, in 1975, community legal aid interviewers were appointed to improve the provincial judicare scheme by applying a system of 'outreach' to benefit those who were institutionalised or otherwise unable to obtain access to legal aid offices (Legal Aid Alberta,1975). Particular attention was paid to those in the mental health institutions at Ponoka and Oliver and a limited enquiry was undertaken to determine the best method of meeting the needs of patients. A regular programme of weekly visits by legal aid interviewers was established in conjunction with an advertising campaign and the utilisation of ward social workers who acted to 'channel' clients; a scheme that is still in operation.[31] In addition, a special programme was organised by Legal Aid Alberta to assist patients at incapacity hearings before review boards; a sudden temporary need that arose from the transitional sections of the <u>Mental Health Act, 1972</u>.[32] A duty counsel scheme, involving private practitioners, was established and hearings were conducted at six provincial institutions, the programme being completed and finally dismantled in July 1975 (Legal Aid Alberta,1976).

The Legal Service Commission in Quebec also made limited efforts to assist mental health patients, although not until 1976. In this year lawyers from the Joliette legal aid bureau, in Montreal, conducted an education programme for mental health professionals at St Charles Hospital (Legal Services Commission,1976). The project, which lasted for 18 months, was designed to make legal aid facilities and legal services known to staff and patients. Legal aid information was and still is, made available at the hospital and patients who need/needed legal assistance when hospitalised, for whatever reason, were/are automatically referred to legal aid bureaux outside the hospital. Patients are then treated as any other legal aid client, having a choice of assistance from either a staff lawyer from a community law centre or a private practitioner.[33] As such, no 'special' legal services exist for patients in the province.

Similar arrangements have been developed by legal aid bodies in other provinces. In Newfoundland, for example, whilst no special arrangements are provided for patients, the availability of legal aid is widely advertised throughout the province's mental hospitals. This, however, is a new development tied to the recent establishment of the provincial Legal Aid Commission (in 1977) and the provincial Mental Health Review Boards (in 1979).[34] No special legal services for patients exist or are planned for the province although the Legal Aid Commission has received applications for legal assistance from patients and agencies for patients, in relation to conventional legal aid matters; such applications are handled in the normal way, in keeping with eligibility and coverage policies.[35]

In Saskatchewan, no special legal services are provided or planned for mental health patients, such persons being treated as any other applicant for legal aid purposes.[36] However, legal aid in the province, organised by the Saskatchewan Community Legal Services Commission, involves a relatively extensive network of legal aid offices and staff lawyers (Saskatchewan Community Legal Services Commission, 1975 - 1979) such that access to legal aid is at least feasible for mental health patients, if not actively encouraged. This contrasts sharply with the situation in New Brunswick and Prince Edward Island where even basic legal aid facilities for the community at large, let alone mental health patients, are sadly lacking.[37] (Legal Aid New Brunswick,1979; Office of the Public Defender,1979).

It is necessary to point out that whilst special legal service facilities for patients were being developed and operationalised by provincial legal aid bodies, independent community legal centres in Canada were and still are, also handling requests for assistance from patients as part of their general operations. I have already briefly discussed the role played by the Dalhousie Legal Aid Service, Toronto Community Legal Assitance Services and the Vancouver Comunity Legal Assistance Society; it is equally vital to acknowledge the work of agencies such as Parkdale Community Legal Services in

Toronto, Community Legal Services in Fredericton, New Brunswick, Calgary Legal Guidance, and the legal services established by the law schools associated with the major universities (National Task Force,1979; Cruickshank & Lacourciere,1979). Although it is not possible to determine the extent to which such agencies provide assistance[38] it is clear that, in many cases, they bridge the gaps in coverage and eligibility created by the policies of provincial legal aid bodies, particularly in provinces such as New Brunswick that only have partial or otherwise inadequate legal aid plans. In addition, because of their policy of making their facilities easily accessible to disadvantaged people and providing specialisation through the practice of poverty law such legal services have attracted the attention of both mental health patients and those in a position to recognise the value of such services for patients (e.g. psychiatric social workers). As a result, such legal services have undertaken some work in the mental health area.[39]

It is therefore apparent that the growth of legal aid systems has been the major impetus for mental patients' legal services in Canada. As Table II indicates, there are inseparable links between the two groups both in an economic and an organisational sense.

TABLE II

PRINCIPAL LEGAL SERVICES FOR MENTAL HEALTH PATIENTS: CANADA 1980

Province	Legal Service	Sponsoring Agency	Funding Agency	Delivery Mode
British Columbia	Mental Patients' Advocate Project	Vancouver Community Legal Assistance Society	Ministry of Justice Canada/Vancouver Comm. Legal Ass. Society/ Legal Services Society	Full-time Legal Aid Office in an institution with additional community office (V.C.C.A.S.)
	Legal Services Society Patient Appointee Service	Legal Society of B.C.	Legal Services Society/ Mental Health Authority	Panel of Private Practitioners on Request.
Alberta	Community Legal Aid Interviewers	Legal Aid Alberta	Legal Aid Alberta	Regular visits to institutions to receive applications for aid.
Manitoba	Community Legal Services Duty Counsel Scheme	Legal Aid Manitoba	Legal Aid Manitoba	Staff lawyers as regular duty counsel in institutions
Ontario	Hospitals Duty Counsel Scheme	Ontario Legal Aid Plan	Ontario Legal Aid Plan	Regular duty counsel in all provincial institutions
	York-Finch General Hospital Legal Clinic	York-Finch General Hospital, Toronto	Ontario Legal Aid Plan	Limited legal clinic in hospital giving advice/assistance and receiving legal aid applications
	Hamilton Psychiatric Hospital Legal Clinic	Hamilton Psychiatric Hospital	Ontario Legal Aid Plan	ditto
	Parkdale Community Legal Services	Parkdale Community Legal Services	Ontario Legal Aid Plan Clinical funding scheme	Conventional community legal centre
	National Legal Resources Service	National Institute on Mental Retardation, York University.	Donner Foundation	Proactive Consumer group, no direct clinical services

TABLE II (continued)

Province	Legal Service	Sponsoring Agency	Funding Agency	Delivery Mode
Ontario (continued)	Advocacy Resource Centre for the Handicapped	Coalition of several consumer groups including The Association for the Mentally Retarded, Ontario	Ontario Legal Aid Plan, Clinical Funding Scheme.	Proactive consumer group. Open centre for any client.
Quebec	Conventional Community Legal Centres	Legal Services Commission, Quebec	Legal Services Commission, Quebec	Enhanced referral system from hospital staff.
Nova Scotia	Patient representation before review boards.	Nova Scotia Legal Aid Commission	Nova Scotia Legal Aid Commission	Referral from review board. Staff lawyer representation.
	Dalhousie Legal Aid Service	Dalhousie University	Dalhousie University/ Nova Scotia Legal Aid Commission	Conventional Community Legal Centre.
Newfoundland	Patient representation before review boards.	Newfoundland Legal Aid Commission	Newfoundland Legal Aid Commission.	Automatic Referral from review boards. Staff lawyer representation.

It should be noted that the Table excludes the many independent, voluntary legal services discussed above, who may, occasionally, deal with mental health issues, and the many patients groups who, through private arrangements, can call upon the services of a private practitioner.

Whilst legal services for patients are not as well developed in the other two Commonwealth countries (England and Australia), the ties with prevailing legal aid systems are equally as apparent. I have already indicated that although, in England, the major patients' representation service is sponsored by a consumer group (MIND) it is still bound to the prevailing legal aid 'system'. Discussions of the general inadequacy of this system are legion although, by dint of the Legal Aid Act 1979 and the recent Royal Commission on Legal Services, some changes are likely in the near future.

At present, under the Legal Aid Act,1974, legal aid is not available for patients appearing before Mental Health Review Tribunals (an important area of legal need). However, advice and assistance may be given by legal practitioners up to the value of £25, or higher with the authority of the Area Secretary of the Law Society (Gostin & Rassaby,1980); a figure that was determined in 1974 (Smith & Hoath,1975). Client contributions towards the cost of services may be required although as Gostin & Rassaby(1980) point out, the majority of patients in hospitals have limited means, such that they are invariably eligible for assistance without the need to make contributions. This still does not resolve the problem of actually providing representation and, whilst many practitioners find ingenious ways of defining 'advice and assistance', most appearances for patients have to be, and usually are, provided on a voluntary basis(Gostin & Rassaby,1980; Gostin,1977). This situation is far from satisfactory and places considerable restraint on the work of patients' representatives (op cit).

It should be noted that similar financial limitations are placed on the second source of legal assistance for patients in England; the community law centres. As I have pointed out elsewhere (Bothmann & Gordon,1979) the financial and administrative aspects of legal aid in England significantly curtail the activities of both established law centres (see, also, Byles & Morris,1977; Zander,1978) and those seeking to provide alternative legal aid delivery systems (notably private firms specialising in poverty law). Loosely co-ordinated by the Law Centres Federation, community law centres developed in most major centres during the 1970s[40] and, as has been noted in relation to Canada, have encountered mental health patients amongst their client group.

A dearth of evaluations and other relevant data renders the task of determining the extent to which such law centres are utilised by patients, difficult in the extreme. For example, the most recent research for the Royal Commission on Legal Services does not appear to have considered the issue, even in a passing fashion (Legal Action Group Bulletin, 1979). However, publications in the area suggest that centres are answering some of the unmet needs of patients (Grace & Wilkinson,1978; Zander, 1978). It is apparent that at least four community law centres have staff who specialise in mental health matters and who are encountering clients with both institution-related problems and more conventional legal needs.[41]

The situation in England is reflected in Australia, the third Commonwealth country that appears to provide some legal services for mental health patients. Such 'legal services' are closely tied to existing legal aid delivery systems. However, in general, Australian legal aid systems seem to be more advanced, economically and organisationally, than those prevailing in England (Disney, et al,1977; Bothmann & Gordon,1979). Despite this, the formalisation of patients legal services has been limited. Indeed, the responsibility has tended to fall on the shoulders of the community law centres many of which are struggling with limited resources and an over-reliance on volunteer staff. In addition, whilst patient groups exist, Australia does not have an organisation with the strength of MIND. As a consequence, patient representation services (where legislatively possible) have been minimal[42] and lobbying for law reform splintered.[43]

As Disney has pointed out (in Bothmann & Gordon,1979) the 'modern era' of legal aid in Australia appears to have started in 1972 with the opening of the first independent community law centre in Fitzroy, Melbourne (see also, Cashman,1973) followed shortly afterwards by the formation of the Australian Legal Aid Office.[44] Taking their lead from the Fitzroy model but, in some cases, with a more profound link to university law faculties, several further community law centres commenced operations in the major cities between 1975 and 1979 building up a small network of centres specialising in all aspects of poverty law and providing the necessary, accessible resources previously absent from the community.[45] As such they served to extend the basic legal aid services organised by the law societies in each state, the Australian Legal Aid Office and schemes provided by state governments (e.g. duty counsel in criminal courts), some of which attempted to follow the trend set towards 'shop front' law centres.

As is the case with English and Canadian community law centres, it is difficult to determine the extent to which such centres have been utilised by mental health patients; a data vacuum that tends to reflect the importance placed on other disadvantaged groups (see, e.g., Neal,1978). However, as I have argued elsewhere, (Bothmann & Gordon,1979) unsystematic observations arising from a two year period of work with one of these independent community law centres suggested the presence of a fairly steady flow of mental health clients requiring legal assistance in both conventional legal aid/poverty law areas and in matters relating to institutions. Such work appeared to have arisen both as a result of direct, patient knowledge of such services and through client channelling on the part of hospital social workers sensitised to the value of free legal resources.[46]

Probably the initial and most substantial realisation of the unmet legal needs of patients in Australia arose, in 1975, in New South Wales with the enquiries conducted by the Edwards Committee in relation to a review of the <u>Mental Health Act 1958</u> (Boehringer,1977; Basten,1976). Although, prior to this review, research had been conducted into the unmet legal needs of the poor in conjunction with the Henderson Poverty Enquiry (Cass & Sackville,1975; Jakubowicz & Buckley,1975) and other studies (Hanks,1975), attention does not appear to have been focused on mental health patients.

In the course of the review by the Edwards Committee the issue of legal representation for patients appearing before Magistrates at Section 12 hearings (post-commitment review of involuntary patients) arose as one of the issues requiring attention (Institute of Criminology,1975); the matter being raised by those lawyers on the Committee who were involved in the legal aid movement. Criticism of prevailing conditions was expressed particularly as it appeared that hearings were farcical, being conducted in a fashion that did not reflect the spirit of the legislation. As a result a sub-committee was formed to investigate, organise, operationalise and evaluate a pilot scheme experimenting with different representation models (Boehringer & Woellner,1977).

The experiment, funded by the N.S.W. Health Commission, commenced at Rozelle Hospital, Sydney, in March 1977 and was concluded in November of the same year. Three schemes were employed - one involving a duty solicitor (duty counsel), one a full time legal officer, and the third involving two full-time, non-legal representatives. An evaluation indicated that whilst representation as a whole had an impact[47] the different delivery modes did not play a significant part other than, in the case of the non-legal representatives, reducing the amount of hostility between representatives and mental health staff(Institute of Criminology; 1978). This latter 'discovery' re-emerged as an issue attracting considerable debate in a subsequent seminar (op cit) where the enduring conflict between health and civil rights needs was reflected in the polarisation of opinion amongst the lawyers and mental health professionals. This conflict remains unresolved and is affecting both the establishment of a full-time representation service in the state (despite the support of the N.S.W. Legal Services Commission) and the passage of a new Mental Health Act.[48]

Although the developments in New South Wales have been disappointing for those advocating reform, the situation in South Australia appears to be somewhat better. Whilst the Rozelle experiment was being devised and operationalised in New South Wales, a Mental Health Act was passed in the South Australian Parliament that not only improved patients' rights (notably by providing substantial review procedures in the case of involuntary patients) but also took into account the need to provide a mechanism for giving effect to such rights (Ligertwood,1977). Although limited to situations involving 'appeals' to the Mental Health Review Tribunal or State Supreme Court, patients were provided with a right to counsel and, in the case of indigent patients, a right to have counsel provided;[49] a substantial departure from the situation prevailing in New South Wales.

The Act was eventually proclaimed in October 1979 (<u>Mental Health Act, 1976 - 1977</u>), Section 39 enshrining the right to representation. With the formation of the South Australian Legal Services Commission in the period between the passage of the Act and its proclamation, the right to obtain counsel seems to have been enhanced, the Commission acting as a conduit for applications. A panel of legal practitioners is maintained under the 'judicare' component of the state legal aid plan and, as at March 1980, some appeals under the Act, were pending (Graycar,1980). It is unlikely that any evaluation of the scheme will be forthcoming for some time although the Legal Services Commission has asked participating lawyers to record details of their activities so that developments can be monitored (op cit).

The situation in Australia, then, appears to be in a state of flux. Mental Health Acts are under review in Victoria (Gordon,1981), New South Wales (Bottomley,1980) and West Australia.[50] If subsequent legislation follows the model set by South Australia (as discussed above) patient representation services of some form can be expected. Such legal services will be provided or organised by the Legal Services Commissions in each state, probably funded in part by the relevant Mental Health Authority.[51]

As indicated, the independent community law centres, notably the Fitzroy Legal Service in Melbourne and the Redfern Legal Centre in Sydney have, for some time, been dealing with mental health cases in both the area of conventional legal aid needs and in relation to matters pertaining to institutionalistion. With the growth of the newly formed 'Australian Legal Workers Group' (an adjunct to the independent community law centres) and its sub-committee dealing with mental health matters (Bottomley,1980), it can be expected that greater efforts will be made to seek out patients in institutions rather than relying on patients' requests for aid. In addition, experiments in 'outreach' such as that employed in 1980 by the Fitzroy Legal Service, will extend legal aid delivery to

Community Health Centres thus affording mental health patients in the community an opportunity to obtain access to legal resources.[52] This is a development that may be quite provident given an apparent general move in mental health system management towards deinstitutionalisation and community treatment programmes.

The developments that have occurred in Australia serve to highlight another factor that can be seen to be generally responsible for giving impetus to the growth of mental patients' legal services in Commonwealth jurisdictions; viz, legislative reform. As I have argued elsewhere (Gordon,1981), legislative change as a result of the combined efforts of consumer groups, patients' organisations (who have enlisted the aid of lawyers) and, to some extent, mental health practitioners (including those associated with mental health authorities) have provided a more clearly defined role for legal workers particularly where such changes have created, expanded or revised review procedures in the case of involuntarily committed patients. In effect, legislative changes appear to have frequently created legal need in a mechanical sense; that is, they have created a need for a) legal or para-legal representation before review tribunals, and b) the advice and assistance related to developing a 'brief' prior to any appearance. It is legal need that has to be met by the provision of additional resources or the development of expertise in the case of existing resources if the establishment of such procedures is to be more than a symbolic act. Herein lies the challenge for legal aid practitioners in the Commonwealth. It is a challenge to which, as I have indicated, some legal services and legal aid organisations have risen.

As I have argued, it is apparent that, particularly in Commonwealth jursidictions, an effective fusion of two movements - legal aid and mental health law - has occurred and is continuing to evolve. In general this can be seen as a positive development for mental health patients in that access is being provided to legal resources that are capable of answering their special needs. As I indicated earlier in this Chapter, answering the special needs of the disadvantaged is the major goal of those practising poverty law. A characterisitic of this process is an evolving sub-specialisation associated with the needs of particular groups. The mental health law movement has, and is, providing the expertise in relation to needs peculiar to mental health patients, whilst the legal aid movement, especially in Commonwealth jurisdictions, is providing both the actual legal service delivery modes and the expertise in relation to needs that fall within the scope of poverty law. However, in the course of this fusion, it is clear that, as might be expected, many of the difficulties associated with both movements are persisting. Indeed an unholy alliance has occurred which may be counter-productive to the mutually sought goals.

As I noted at the beginning of this Chapter, a number of complex problems have developed with the evolution of the legal aid movement. The possibility has emerged that legal aid systems may be more lawyer-serving than client-serving. There is an apparent contradiction between serving the needs of individual clients and serving the needs of the client group. Reformative actions have been limited because practitioners are uncertain in relation to the type of legal action necessary to alleviate poverty. Similarly, as I noted in Chapter 2, problems have also developed for the mental health law movement notably in relation to the impact of many of the reforms they have generated. Therefore, in as much as some developments may be to the benefit of mental health patients, others may not.

In this context a two-part question arises, "are legal aid practitioners really answering the legal needs of their clients and are mental health lawyers really acting in the 'best interests' of patients?" Both movements may have a perception of the 'needs' of their clients but are these perceived needs truly understood and truly reflective of clients' perceptions of need? In the type of situation prevailing in Commonwealth jursidictions where legal aid and mental health law are so tightly interwoven, it is apparent that, just as a functional confusion associated with the development of legal aid inhibited, inter alia, a closer liason with civil rights groups, so it has also provided little time to reflect on the directions being taken. In general, practitioners have proceeded on the assumption that what they are doing is in the 'best interests' of their client group: social reform that will benefit the disadvantaged can be effected through legal action. But, what type of reform, reform for whom, and will the reform have the desired impact?

These vexing questions have not, as I have indicated, escaped attention in the context of legal aid delivery in Commonwealth jurisdictions, as a whole. However, they do not seem to have been raised in relation to the special circumstances affecting the provision of legal services for specific groups, particularly mental health patients. In Commonwealth jursidictions, practitioners already affected by the problems associated with the legal aid movement also confront a profound contradiction that has arisen with the evolution of mental health law; viz, a conflict between the health needs of patients and their legal, notably 'civil rights', needs. In the daily practice of law on behalf of mental health patients this has a particular significance for the activities of legal workers who are largely restrained by the content of the principal legislation affecting their client group. Paradoxically this is often the same legislation that has, as I have suggested, encouraged the growth of legal services. Because the contradiction between health and legal needs has been recognised, attempts have been made by legislators to find a balance between what are, in effect, competing perceptions of patients' needs. In doing so, such legislators may have created more confusion than compromise; a situation that intensifies rather than dispels conflict and which perhaps does little to create an effective process for answering the real needs of patients. Similarly, where legislators have chosen to ignore the issue (usually by way of inaction in relation to legislative reform), the conflict is again perpetuated.

The locus of the problem seems to lie with competing perceptions of patients' needs. It is a conflict between perceptions held by psychiatrists, lawyers and patients the resolution of which will be the next stage in what appears to be an evolutionary process affecting the provision of legal services for mental health patients. In a dialectic sense, the current situation appears to present an antithesis from which a synthesis is slowly emerging. Coming to understand this central problem may provide not only an appreciation of the difficulties involved in the current situation but also assist to guide or perhaps 'engineer', the content and form of the synthesis as it manifests itself in the different jurisdictions.

The next chapter will, therefore, examine the concept of need, the associated concept of 'best interests', and explore the competing perceptions of need held by psychiatrists, patients and lawyers. In the course of this exploration the possibility will be raised that, in fact, substantial agreement exists beneath the apparent conflict. As such, the competing groups may be 'tilting at windmills' in the context of inter-profession rivalry; a process that is occurring perhaps at the expense of patients. In an attempt to expand upon the problems confronting patients' legal services in Commonwealth jurisdictions created by an attempt, on the part of legislators, to find a compromise between the competing perceptions, the chapter will be followed by an examination of the central aspects of Canadian mental health and related legislation.

NOTES

1: It is interesting to consider the apparent tendency for any organisation established to 'help' the poor to evolve into a monolithic enterprise serving the interests of its employees more than the interests of those whom it was established to help. For example, the Salvation Army, originally conceived as an agency to provide immediate relief for the poor of London, has evolved into a massive international corporation, whilst the poor are still with us (particularly in London). The same process of evolution seems to be affecting the legal aid movement. Certainly both organisations do much to assist the poor in an immediate sense but, in the long term, they appear to do little to affect the enduring problem of poverty. However, for an example of an organisation that tried to break out of this process see, Liffman,1978 (see, also, Stanton,1970).

2:

> "Canada, as a signatory of the Universal Declaration of Human Rights (proclaimed by the United Nations' General Assembly on December 10th,1948) and of the International Agreement on Civil and Political Rights (adopted on December 16th,1966 by the same assembly), committed

> itself to respect the legal rights of every individual, namely the right to legal representation, free of charge, if it is beyond the financial means of the individual, everytime the interest of justice so demands it (Sec. 2)d)). The Canadian federal government solemnly proclaimed in the 1960 Bill of Rights, the right of any individual under arrest or detention "to retain and instruct counsel without delay"(Sec 2)c) ii)." (National Task Force,1979:4)

Whilst the obligation under the United Nations Declaration may seem to have been discharged by virtue of the Bill of Rights, subsequent Supreme Court interpretations suggest that the Declaration is honoured in the breach (see Chapter 2). It is interesting to further note that Australia was a signatory to the same Declaration but does not have a Bill of Rights. Further, prior to 1973, it did not have an effective, national system of legal aid.

3: The growth of fixed tariff 'law shops' can also be seen as an extension of legal aid. Such enterprises serve to provide access to legal services for those formerly deterred by the fear of confronting exhorbitant and concealed fees for services that might be beyond their means.

4: In this study of mental health patients in a London hospital (n=558) the researchers found the following:

1. 13.7% of those admitted came from transitory accommodation or were of no fixed abode.
2. Of the 456 patients discharged 28.7% left with no fixed

abode or had changed their address during hospitalisation (suggesting a transitory state).

3. Of 102 patients in one ward on one day, 28.4% came from transitory accommodation or no fixed abode, 64.7% were unemployed, and 50% were living alone when outside the hospital.
4. Of the 74 in-patients (long term stay), 40.5% were homeless and 36.5% had no visitors, suggesting the absence of any community supports. As such it was assumed they came from socially disorganised circumstances associated with poverty.

5: 372 US 335 (1963)

6: 387 US 1 (1967)

7: For example, The New Jersey Involuntary Commitment Code and Inpatient Legal Services Bill; The Illinois Mental Health and Developmental Disabilities Code: SB 250.

8: The spectrum of legal need will be discussed in depth in the next chapter.

9: In Commonwealth jursidictions, the reformative impact of this area of law has been slow to emerge. Very few cases have established precedents and their impact has been limited. See, for example, Green v Daniels [1977] 5 ALJR 463; R v Greater Birmingham S.B.A.T., ex parte Simper [1973] 2 All ER 461; R v Barnsley S.B.A.T., ex parte Atkinson [1977] 3 All ER 1031.

10: I am referring here, particularly, to the actions of the Nixon Administration in the United States as exemplified by Vice President Agnew's condemnation of the legal aid movement in 1972. Restraints on legal aid lawyers were included in the subsequent (federal) Legal Services Corporation Act, 1974 in an attempt to stop "politically inspired social engineering" that did not complement Republican ideology.

11: This specific issue has been extensively discussed by those involved in the legal aid movement. In general, the concern is with the extent to which 'public interest law' (which includes civil rights issues) can be practised in Commonwealth jurisdictions. As many writers point out (Partington,1979; Cappelletti & Jolowicz, 1975; Legal Aid Committee of Ontario,1972) 'successes' that have occurred in this area in the United States cannot be repeated in the Commonwealth. Many reasons for this have been advanced. For example, Partington (1979) points to, inter alia, the fact that, in the United States many public interest cases challenge the constitutional propriety of statutes, regulations and institutional practices.

In the absence of such a constitution, public interest lawyers in other jurisdictions are unable to turn to the same protective mechanism. Further, as others have also argued (Legal Aid Committee of Ontario,1972) there is a willingness, in the United States, to acknowledge that judges have an innovative role to play when deciding cases. To assist them, there is no strict doctrine of precedent, and a tradition of reform-oriented litigation. Finally, considerable technical difficulty confronts public interest lawyers in the Commonwealth. Although the situation may be changing, the general lack of any facility for undertaking 'class actions' places a heavy burden on practitioners (Partington,1979; Williams,1979; Debelle,1980).

In the search for effective mechanisms, writers have discussed the utility of Relator/Representative actions (Dickens,1974; Cappelletti & Jolowicz,1975); the use of declaratory judgements(Zamir,1962; Birtles,1973; Scarman, 1974); the use of prerogative writs (Birtles,1973; Gifford & O'Connor,1979; Arden,1974); the use of injunctions (Birtles, 1973; Gifford & O'Connor,1979); and the use of international remedies (Gostin,1979b,1979c; Nash,1975). In general it seems to be agreed that none of these is a suitable replacement for actions that flow from a constitutional basis.

This is particularly the case in relation to mental health law issues. Although very few actions have been attempted, in this area, in Commonwealth jurisdictions, it is possible to consider many mental health issues in the same context as prison law. As unfortunate as this may be for mental health patients, it is clear that a growing body, 'institution law', is slowly emerging. Mental health and penal issues have been jointly discussed in the context of legal need (Brakel,1978; Dickey & Remington, 1976) and there is considerable support for placing the problems of both groups into the same conceptual framework (Huey,1975). Commonwealth developments in prison law are, therefore, relevant (see, e.g., Price,1977; Judson & Laidlaw,1975; Conroy,1980; Vandervort,1977) particularly where they involve civil rights issues. This is especially true where prisoners' rights that could be applied equally to mental health patients, are successfully established (see, e.g., Nash,1975; Gostin,1979c).

In general, litigation in mental health law has been restrained to the confines of administrative law. This is because current activity in the area is centred around the role and function of administrative tribunals set up to deal with the issues of involuntary commitment and continued detention. Further it is relevant because, as Reid argues (1971), administrative law is "the law of human rights"; it seeks to control the controllers and administrators of society. As mental health patients are susceptible to the whims of administrators, the related area of law takes on a particular significance.

This assumes, however, that administrative law remedies are effective. As Scarman has argued (1974), this is not entirely the case particularly in relation to the prerogative writs. Habeas corpus, for example, is generally recognised as a weak remedy other than in truly extreme cases of arbitrary and unlawful detention (Weisstub,1980; Gostin & Rassaby,1980; Gostin,1979b,1979d; Gifford & O'Connor,1979). In practice it is not Blackstone's "great and efficacious writ." Similarly, the writs of mandamus and certiorari first require the presence of legislation or regulations that recognise rights (Arden,1974). In any event, those cases that have been attempted invariably founder in the face of judicial reluctance to censor the work of officials (Arden,1974; Scarman,1974; Birtles, 1973; Gostin & Rassaby,1980; Gostin,1979b). Even where an action may succeed, the absence of any consitutionally entrenched and judicially supported Bills of Rights, usually means that the reformative effect is short-lived. As Partington points out (1979) and as the fate of litigation suggests (see note 9 supra), court decisions can be simply reversed by new legislation or regulations. In addition, 'victories' may not result in substantial change because of the many 'discretions' inherent in administrative regulations. For example, in a recent Candian case (Abel, et al, v Penetanguishene Mental Health Centre (1979) 46 CCC (2d) 342), a writ of certiorari succeeded but its effect was dissolved by the fact that the court simply directed the relevant party to exercise his discretion as he thought fit. As a result, the impact of the successful action was negligible *vis-a-vis* the rights and needs of the applicants. To some extent the impact of this particular judgement has been qualified by the Ontario Court of Appeal in *Re Abel et al and Advisory Review Board* ((1981) 56 CCC (2d) 153). However, as I noted in Chapter 2, considerable discretion is still left in the hands of the Review Board.

Although a variety of alternative strategies are being discussed, they are all at an embryonic stage. For example, Linden (1980) has argued convincingly for the use of the tort of negligence as a weapon for the control of the activities of review tribunals. Such notions, however, are rather desperate attempts to fill the gap left by the absence of both constitutionally entrenched Bills of Rights *and* effective mechanisms for protecting rights. Although this situation may change in Canada (a constitutionally entrenched Charter of Rights may appear within 12 months), it is argued that this will alter very little. A fuller debate of this possible development is, regretably, beyond the scope of this thesis.

Similarly, in the case of the United Kingdom, increasing use of the European Commission on Human Rights may prove to be an important development. Legal aid is available for persons pleading causes before the Commission (Seviour,1975) a situation which effectively improves its accessibility. Also, as I noted in Chapter 2, several cases in the mental health and prisoners' rights areas have been placed before the Commission (Gostin & Rassaby,1980; Mental Disability Law Reporter,1979a; Gostin,1979b,1979c; Nash,1975; Muchlinski,1980). However, the long term impact of the Commission on civil rights issues in the United Kingdom is difficult to determine.

12: It is apparent that, overall, Canada has the most advanced legal aid systems of all Commonwealth countries. As I will argue this can be seen to account for the more advanced developments in relation to mental health advocacy.

13: New York Mental Hygiene Law, Section 88, as amended Section 29.09.

14: As Weisberg has noted (1979), the 1978 fiscal year marked the official start-up of Protection and Advocacy systems for the developmentally disabled in most states. Three million dollars was authorised, nationally, for their establishment.

15: Data obtained through correspondence with the following United States agencies between June and October 1980:The Bureau of Developmental Disabilities, The National Legal Aid and Defender Association, The Mental Health Law Project, The Practising Law Institute. The actual number of services is in a constant state of flux due to closures and new establishments.

Whilst the agencies attempt to maintain a constant check on developments there is no, single national body charged with the task of monitoring services, to whom such services regularly report.

16: Berkley Neighbourhood Legal Services, Berkley, Cal.; Community Legal Aid Society, Wilmington, Dela.; Legal Assistance Foundation, Chicago, Ill.; University of Maryland Law Clinic, Baltimore, Mylnd.; Ocean - Monmouth Legal Services, Red Bank, N.J.

17: Amongst many suits pursued by these organisations is Wyatt v Stickney, the landmark class action against the State of Alabama. See Chapter 2 (also Schwartz,1974).

18: Branches are located in Medical Lake, Monroe, Olympia, Seattle, and Walla Walla.

19: Legal services are provided by the law schools associated with the University of Connecticut (West Hartford), the University of Toledo (Toledo, Ohio), the University of Texas (Austin), the University of Wisconsin (Madison), and Washington and Lee University, Lexington, Virginia (the Western State Hospital Project).

Legal Aid Societies providing services include the Legal Aid Society of Denver (Colorado); Vermont Legal Aid (Vermont State Hospital, Waterbury); Bergen County Community Mental Health Law Project (Hackensack, New Jersey); Legal Aid Society of New York (New York); Carolina Legal Assistance (Raleigh, North Carolina); and the Mental Patient Civil Liberties Project, Philadelphia, Pennsylvania.

20: No 73-205 (ND Ohio, Sept 1st 1976), also 384 F Supp 1196 (1974).

21: For example the Illinois Mental Health and Developmental Disabilities Code:SB 250

22: Information obtained from interviews conducted in 1979 and 1980 with former members of the initial advocacy project and Mr Gerald Green, at that time Director of the Mental Patients' Advocacy Project. See also Legal Aid Society, 1976.

23: Communication with Mr. Gerald Green of V.C.L.A.S. and Ms. Marilyn Sarti of the Mental Patients' Association; May, 1981. In addition to the loss of essential funding, the Project was deprived of its premises in the hospital grounds. At present, a temporary legal service is available through the Mental Patients' Association drop-in centre at Riverview Hospital and the V.C.L.A.S. office in an inner suburb of Vancouver. Former Project staff are continuing to provide specialist services for patients although activities have been seriously curtailed.

24: Personal conversation with Mr. J.Ohlson, Legal Services Society of B.C.; August 1980.

25: It should be noted, however, that Dalhousie Legal Aid Service provide and have provided, assistance to mental health patients for some time, as part of their general delivery system (personal conversation with former and present Dalhousie L.A.S. staff (December 1980) and correspondence with the current Executive Director, Mr Archibald Kaiser (August 1980)). Similarly, the Nova Scotia Legal Aid Commission also extends limited coverage to patients, mainly in the area of review board hearings (correspondence with Mr. Gordon Murray, Executive Director of Nova Scotia Legal Aid, June 1980).

26: An issue that was to arise again during the public hearings in relation to changes to the Ontario Mental Health Act (Standing Social Development Committee,1978).

27: Little appears to be known about the impact of the original experiment or the current system. The Ontario Legal Aid Committee Annual Report in 1975 indicates that during the period

March 1st 1975 to August 31st 1975, 164 patients were assisted although no further information was provided or appears to be available. Indeed no recent assessments have been made of the current programme (personal correspondence with the Director of the Ontario Legal Aid Plan, Mr. Andrew Lawson, Q.C., June 1980).

28: Little is known about the operations of this legal clinic. Monahan (1975) reports that in the first six months of its operation in 1974 it saw over 200 clients. 75% of cases involved domestic matters, 10% landlord and tenant, and 15% miscellaneous. No civil rights issues were pursued, as a policy, nor did the clinic involve itself in disputes between patients and the hospital. Despite numerous attempts by this writer to obtain information from the clinic staff, no response has been forthcoming.

It should also be noted that similar schemes appear to have been attempted in more recent years in Ontario. For example, Savage & Vaughan (1978) reported centres for legal advice and legal aid applications funded by the Ontario Legal Aid Plan, at the Lakeshore Psychiatric Hospital in Toronto and the Hamilton Psychiatric Hospital. By 1979, however, the Lakeshore Hospital scheme had been terminated (Ontario Legal Aid Plan, 1979) although the reasons for this remain unknown. It should be noted that this hospital was the site of the earlier 'ombudsman' experiment. The relationship between both schemes and the Legal

Aid Plan duty counsel scheme is unclear although it is apparent that this hospital has been the site of different experiments in providing 'legal services' for patients. Further research should be conducted to examine the impact of these schemes on a comparative basis.

29: Personal correspondence with legal service staff and with Professor R.Gathercole of University of Toronto (July/August 1980). During its period of operation the service dealt with a range of work. 60% of cases involved conventional poverty law issues (e.g. family matters, debt, landlord and tenant disputes), 25% of cases were related to the institution (e.g. disputes over treatment modalities, release issues, and review board hearings), and 15% of cases involved social welfare law matters. No test cases or other reformative actions were undertaken.

30: The following institutions are served: Brandon Mental Health Centre (served by the Brandon Community Law Office), Selkirk Mental Health Centre (served by the Selkirk-Interlake Area Office) and the Health Sciences Centre in Winnipeg (served by its own Legal Aid Manitoba branch office). Information from personal correspondence with Mr. Allen Finebilt, Deputy Director of Legal Aid Manitoba, (August 1980). See also Legal Aid Manitoba Annual Reports, 1975 to 1979.

31: Personal correspondence with Mr. Thomas Schollie, the Executive Director of Legal Aid Alberta (June 1980).

32: As a result of the Act, certificates of incapacity were no longer issued in the case of every patient admitted involuntarily to a mental hospital. Transitional sections of the Act provided that any patient could, and the public institution should (if the patient did not), apply to the Review Board to have an outstanding certificate of incapacity cancelled. As, at that time, there were over 2000 patients in the province affected by the transitional provisions, Legal Aid Alberta approved a duty counsel scheme to assist patients(and the institution).

33: Personal correspondence with Mr Jacques Lemaitre-Auger, Secretary of the Commission Des Services Juridiques De Quebec (July 1980).

34: Personal correspondence with Ms. Irene MacEachern, staff solicitor with the Newfoundland Legal Aid Commission (September 1980).

35: See note 34 supra. It should also be noted that coverage is more extensive where the applicant is suffering from physical or mental disability.

36: Personal correspondence with Mr. S. Whelan, staff solicitor with the Saskatchewan Community Legal Services Commission, (August 1980).

37: Whilst the situation in Prince Edward Island may be justified because of the small population (legal aid is limited to criminal and family matters only) the same cannot be validly offered in the case of New Brunswick. Annual Reports of Legal Aid New Brunswick constantly indicate the unsatisfactory nature of a legal aid plan that only deals with criminal law matters, to the exclusion of <u>all</u> civil matters, a problem that affects the provision of aid to mental health patients. As the Provincial Director indicates in recent correspondence with the author (June 1980) "if and when this province would implement a full blown civil legal aid plan, I expect we would staff mental institutions with duty counsel on a regular basis." As I will indicate later in this thesis, this raises problems for mental health patients seeking to pursue legislatively prescribed rights in the province.

38: Evaluations that have been undertaken tend to examine the overall issue of practising poverty law rather than answering the needs of mental health patients, <u>per</u> <u>se</u>. For example see Parkdale Community Legal Services,1979.

39: At Parkdale Community Legal Services, for example, staff have dealt with issues relating to public trusteeship, social welfare law and release from institutions as well as more conventional legal problems(conversation with Ms. Mary Hogan, Director of Parkdale, April 1980). In a brief presented to the Ontario Standing Social Development Committee in June 1978 (supra) (the Committee considering changes to the Mental Health Act, RSO 1970 c.269). Ms. Freda Fyles and Mr. Morris Title of Parkdale expanded on the experiences of the legal centre in the mental health area. Although they were unable to provide substantial data, they indicated that for "several years" legal and community workers had been dealing with detention and treatment disputes. As the legal service lacked expertise in the area they were often forced to 'brief out' to private practitioners specialising in mental health issues. However they were often able to negotiate matters for patients without recourse to other avenues of legal action (see, also, Committee of Mental Health Services in Ontario (1979) for a further but brief discussion of the role of Parkdale Community Legal Services).

40: The first community law centre opened in North Kensington, London, in July 1970.

41: The Camden Community Law Centre, The Lambeth Community Law

Centre and The Tower Hamlets Community Law Centre, in London. A specialist is also working in the Manchester Law Centre. Information from the Law Centres Federation Chairperson, Mr. Phil Kemball, during personal conversation; London, May 1980.

42: It appears that, as was the case in England before the formation of MIND's representation service, some representation was provided by various Civil Liberties organisations in the different states (Boehringer & Woellner,1977). Little is known about the extent or nature of such representation.

43: This situation appears to be changing with the formation of groups seeking law reform in West Australia, Victoria and New South Wales. In Victoria, The Council of Social Services (VCOSS) have been actively organising interested parties since September 1980 in an attempt to form a lobby group to influence the content of the proposed, new, Victoria Mental Health Act, such a lobby group including members of community legal centres (e.g. this writer)(see Gordon,1980).

44: Originally conceived as a nationwide network of legal aid offices funded and administered by the Commonwealth Government, this organisation suffered considerable setbacks and is now being slowly dismantled with the advent of state legal aid commissions.

45: Although legal aid was available through professionally organised schemes, obtaining access to a practitioner was frequently problematic. Community law centres (it is claimed) effectively broke down the barrier. Community law centres now operate in the suburbs of Melbourne (Fitzroy, West Heidelberg, Nunawading, Springvale, North Frankston), Sydney (Redfern, Marrickville, Parramatta, Mt. Druitt), Adelaide (The Parks) and Brisbane (Caxton Street).

46: Whilst the work (from 1977 to 1979) was principally at the Fitzroy Legal Service substantial and regular dialogue with other community law centres in Australia suggested that the observations were not unique.

47: Both favourable and unfavourable results were noted. Whilst the number of releases increased (assumed to be a favourable result), so did the number of 'deferments' (assumed to be an unfavourable result).

48: Personal conversation with Mr. Ken Kershaw, Deputy Director of the N.S.W. Legal Services Commission, in Sydney, September 1980 and correspondence with Mr. Peter Cashman of the N.S.W. Law Foundation, February 1981. See also, Bottomley (1980); Cashman, (1978); O'Shane, (1978); Boehringer & O'Shane, (1978).

49: This section of the Bill has been trenchantly summarised by Ligertwood (1977):

> "...only in exceptional circumstances the person maybe allowed to represent himself, otherwise the person in respect of whom the appeal is brought must be represented by counsel, either chosen and paid for by himself, chosen by himself and paid for by the government, or chosen by the Law Society and paid for by the government."

50: <u>The West Australian</u>, October 23rd 1980.

51: Information obtained from discussions with Mr. Ken Kershaw, Deputy Director of the N.S.W. Legal Services Commission, and Mr. Julian Gardner, Director of the Legal Aid Commission of Victoria; September 1980.

52: In response to a concern that the community was not utilising or becoming involved in the management of the legal service, a decentralised 'outreach centres' plan commenced in January 1980. 'Natural' meeting places were identified in the legal service catchment area and, rather than waiting for clients to use the legal service via its central office, legal workers attend each meeting place once a week. Designated meeting places included a local public house (bar), (at which 43 clients were seen over a 6 month period), a youth club, two self-help centres for the unemployed, four public housing sites, two elderly citizens clubs, one community centre, one attendance centre, one Salvation Army centre, and three community health centres (personal conversation with the Community Development Officer, Mr John Finlayson and other legal service staff, September 1980).

IV. THE NEEDS OF MENTAL HEALTH PATIENTS: A CONFLICT OF PERCEPTIONS

With the evolution of the legal aid movement, the issue of 'legal need' has been subject to considerable discussion. Similarly, the extent to which such need was (and is) being met by legal services, both those provided by legal aid organisations and those made available through private practitioners, has been exposed to scrutiny (Zander,1978; Morris, *et al*,1973; Jakubowicz & Buckley,1975; Cass & Sackville,1975; Curran,1977; Byles & Morris,1977; Abel-Smith,*et al*,1973; Bindman,1979; Smith,1980; Morris,1978; Bradshaw, 1972).[1] This has given rise to research in the area, the results of which have, in turn, provided further impetus to the legal aid movement (e.g., Curran,1977; Messier,1978; Cass & Sackville,1975).

In many ways, the sum output of the dialogue in relation to 'legal need' has been more confusing than clarifying. As Zander argues,

> "...when one comes to attempt a definition of concepts such as 'the need for legal services,' or 'an unmet need for legal services', or even 'a legal problem', formidable and indeed insoluble difficulties appear."(1979:273)

A principal difficulty lies with the locus of the definition for different notions of 'need' and the usefulness of legal action as a method of meeting such need can be found to be dependent on the 'person' who is offering the definition. Clients and lawyers may have varied images of what is required or needed and what can or should be done; even reference to law itself (that is, its content) will not clarify the situation for existing law (in its various forms) may not adequately reflect 'need' as defined by either party.[2] Further, 'need' may be determined by socio-economic status and as my earlier discussion of poverty law may have suggested, involves considerable variation even within an essentially similar 'legal' context. It has also been argued that 'need' may be expanded, or even created, by the simple presence of services designed to answer 'need' (Zander,1978) - particularly where, in the case of legal services, practitioners apply their perception of what is necessary or required for their client group independent of an appreciation of the perceptions of that group. Such an approach is suggestive of a situation where practitioners assume that the client group is unable to determine and/or articulate, that which might be in their 'best interests'; an approach that, in the context of legal aid delivery and the practice of poverty law, can be seen to be highly problematic. At the same time, however, it must be noted that the legal aid movement has attempted to assess the extent to which it is answering needs, as perceived by clients. In general, research associated with such assessments demonstrates a high level of client satisfaction with legal services and, where criticisms are made, suitable responses have been forthcoming (see, e.g. Messier,1978; Bothmann & Gordon,1979).

However, it has also been pointed out (Zander,1978; Lewis in Morris, *et al*,1973) that even where 'need' might be mutually recognised by lawyers, clients and, indeed the law, *meeting* that need in the most effective way may not necessarily call for legal action. As Lewis has argued, (*op cit*) it may often be the case in a legal aid setting that the interests of a tenant whose roof is leaking would be better served if he fetched a ladder rather than a lawyer. This issue seems to have particular poignancy in the context of clients who are mental health patients, given that their health and legal needs may often come into conflict to the point where attempting to resolve a problem by recourse to law may produce an undesired outcome(Bothmann & Gordon,1979).

On the other hand, active assertion of needs through collective legal action may be essential. Landlords may consistently refuse to repair roofs that are beyond the help of one tenant with a ladder. As Galanter has argued (1975), the status of an individual or group of individuals who are confronting others in the context of a dispute with a legal remedy may have an effect on outcome. Those who are 'one-shot' players, *vis-a-vis* the legal system, are at a severe disadvantage when in conflict with those who are 'repeat players', such that their collective or individual interests (or needs) may not be correctly advanced. Only a conversion of 'one-shot' players to the 'repeat player' status can properly overcome the limitations placed on the articulation of their position. In this sense, meeting the legal needs of such people (epitomised by those from disadvantaged groups) involves providing them with access to 'repeat players' who will act on their behalf; a role played by lawyers involved in legal aid delivery systems.

As Morris has indicated(1973), where 'needs' are redefined as 'rights' (rather than privileges) it is possible to see concrete evidence of the impact of the infusion of power on behalf of disadvantaged groups discussed by Galanter (op cit). Where this process includes the establishment of rights in the context of 'social welfare law', it involves the redefinition of welfare privileges as 'new property' that was sought by Reich (1964)(see, also, Mayhew & Reiss,1969). In this sense it is also possible to argue that the power that arises does so as a result of the client group experiencing the transference of status from being 'one-shot' players to being 'repeat players' and of having their 'property' rights recognised and responded to, by legal practitioners (Mayhew & Reiss,1969).

At the same time, however, the emergence of 'rights' may, in themselves create legal 'need'. 'Rights', it can be argued, are re-interpreted 'needs' that, as a result, become enforceable. 'Rights' may have to be protected or otherwise given effect through the utilisation of legal services. The establishment of certain bodies in conjunction with the recognition of rights (e.g. administrative tribunals of one form or another)[3] may, as I have pointed out, create a need for legal assistance in a mechanical sense. In this respect, the essence of Zander's contention (1978) that 'legal' need may be created or expanded by legal action is seen to be valid although possibly refined by the addition of this further, perhaps more positive, dimension. As I argued in the previous chapter, this process appears to have occurred in Commonwealth jurisdictions in relation to legal services for mental health patients and can be seen to be a driving force behind the actual establishment of such services.

Although, as I have indicated, the legal needs of both the community as a whole and of those occupying low income-status have been explored, the needs of some specific disadvantaged groups have not been subjected to the same extensive examination. This situation is particularly true in relation to mental health patients. As a consequence, it is unclear whether those involved in the delivery of legal services to this group are both appreciating and answering their unmet needs.

It is possible, however, to turn to a variety of sources of information and, from these, extract important insights and some limited data. The recorded experiences of legal aid workers (e.g. Dickey & Remington,1976; Strand,1972), official evaluations of specific mental health advocacy projects (e.g. Steadman & Brooks,1977), formal proposals for the establishment and funding of projects (e.g. Bolton, et al,1975), and briefs presented to committees or other bodies concerned with mental health reform (e.g. Standing Social Development Committee,1978) all assist the enterprise. Similarly it is useful to turn to research conducted to assess patients' needs from the patients' perspective (e.g. Brakel,1978; Epstein & Lowinger,1975), academic treatments of specific mental health law issues (e.g. Anand,1979; Verdun-Jones,1979), evaluations of, or commentaries on, the work of specific mental health agencies or bodies (e.g. review tribunals: Haines,1978), examinations of specific injustices that arise in relation to mental health patients (e.g. Endicott,1980), analyses of the law as it relates to mental health patients (e.g. Venables,1975), and finally, analyses of mental health and related legislation. Each provide insights into the legal needs of patients and the extent to which such need is either met or unmet by existing legal resources. Such an exercise also provides information in relation to a host of other issues of importance in this area of exploration. It illustrates the dilemmas confronting those seeking to answer unmet legal need; the various legal service models available to practitioners; the different goals sought by the range of organisations involved in delivering legal services; and the restraints on their activities imposed by a) legal aid policies and b) more general, procedural and legislative limitations in the different jurisdictions.

In relation to the legal needs of mental health patients the difficulties articulated at the beginning of this chapter are most apparent. Although some work has concentrated on the patient/client perspective by directly canvassing their views, a preponderance of the material is based upon 'lawyer-centred' perceptions of need. In many instances these may be truly reflective of the client's perspective given that many of the lawyers are in the employ of, or closely associated with, patients' organisations; in this sense they act, quite appropriately, as a 'mouthpiece' for the community of patients (see, e.g., Standing Social Development Committee,1978). In other instances, however, it is possible that analyses may be based on practitioners' perceptions of client need as moulded by their own view of what is in the 'best interests' of the clients. Such a perspective may be influenced by their particular ideological persuasion in respect of the pursuit of patients' rights, as determined by the nature of their particular operational milieu and, as a corollary, the possibilities that exist for aggressive, partisan, advocacy. An examination of the perceptions of need and the principal concern or '<u>leit-motif</u>' as expressed by both lawyers and patients/clients, will provide not only an overall picture of the needs (legal and otherwise) of patients but also an image of some of the problems that might exist in conjunction with the larger contradiction between health and legal needs.

Prior to doing so, however, it is necessary to examine and outline the suggested, larger contradiction between health and legal needs. This will provide two things; i) a discussion of the centrality of the contradiction in the context of mental health issues; and ii) an exposition of a third perception of patients' needs, namely that held by mental health staff (psychiatric-centred perceptions of need).

It seems clear that the tensions and conflicts that exist between patients, lawyers and mental health staff can be traced to the divergent views held by, in particular, lawyers and psychiatrists in relation to what is in the 'best interests' of patients. In general, this dispute arises in the context of a disagreement over the primacy of, on the one hand, civil rights needs, and on the other hand, health needs (Stone,1975; Barton & Sandborn,1978). At this stage in the evolution of mental health reform a consensus on the matter seems distant, principally because there seems to be no way of determining either what 'best interests' means as a concept or in establishing how the notion is to be 'objectively' applied in any given circumstances. As Rae-Grant has noted (1979):

> "...a myth (has) bedevilled both psychiatry and the law, namely, the frantic search for "the best interests."...What (has) been operating for a long time

> but (cannot) be openly stated (is) that in many situations there (is) no best answer."(1979:17)

Indeed, as he further argues, the ill-defined notion of 'best interests' has been used "as a justification for doing things which in the end may turn out to be anything but in the best interests of the (individual)" (op cit:18).

It seems that the notion of 'best interests' can be equated with 'need' although here one faces the problem of competing perceptions of need. That is, where a patient/client perceives and articulates a need it is normally to be assumed that the individual knows what is in his or her 'best interests'. However, this judgement, acceptable in conventional circumstances where it can be at least assumed to be 'informed', is not seen as legitimate in the mental health context.[4] Indeed the whole issue of competency, which plays a central role in the handling of mental health patients and in mental health law, has evolved (from the doctrine of parens patriae) because of the assumption that patients' judgements will be detrimental to their 'best interests'(Price, 1973). As Gostin argues,

> "...competency may be defined as reaching a reasonable result - under this standard, persons who make judgements which are contrary to their best interests as perceived by others, are deemed incompetent. This standard is wholly paternalistic as its explicit assumption is that a person's fate is better made for him than by him, because others wiser than he have greater knowledge of his best medical and social interests."(1979a:152)

Clearly, then, in determining what is in an individual's 'best interests', it is assumed that one can turn to 'objective' criteria constructed from superior knowledge through which predictions of outcome can be generated (Goldstein, et al,1973). That is, an 'equation' can be constructed which, given a configuration of existing circumstances and alternative courses of action, can be used to select an appropriate strategy given the presence of an objectively determined outcome which maximises benefits and minimises loss.

The problems inherent in this context are legion and extend to both psychiatrists and lawyers. In the first instance, although tidy, a blanket assumption that all patients are incompetent and all mental health staff are competent does not seem to be particularly sound. Clearly, in keeping with the doctrine of parens patriae, the position of a mental health patient is equated with that of a helpless being. As Stone has argued, the doctor-patient relationship in the mental health context,

> "...has been described as similar to that of parent and child. The physician possesses expert knowledge and technical competence. He has a specific rather than general parental function since his expertise extends only to matters of health. His sole motivation is to promote the welfare of the patient, before all of his personal interests. The patient is expected to assume a child's role...He is 'incapacitated', excused from his normal functioning and, like a child, becomes dependent on others to take care of him...For help he turns to the physician. The physician's specificity of function and altruistic motivation legitimate his assumption of power over the patient... because the doctor is expected to resolve the patient's problems in the best interests of the patient. This is the prevailing standard of

professional responsibility."(1979b:321)

As Goldstein has pointed out (1979) this invariably involves a process whereby, "well intentioned people who 'know' what is 'best'...impose their personal, even if professional, preferences on others" (op cit:5), a process which, he argues, can only be controlled by exchanging the 'best interests' standard for the 'least detrimental available alternative' standard (Goldstein, et al,1973). The patient is perceived to be incapable of making judgements and as such any expression of 'need' is ill-founded and ill-considered because of the medical disorder. Such an assumption does not take account of the significance of both the nature of the relevant illness and the nature and complexity of any judgement, when attempting to determine the 'competency' inherent in either a decision or an articulated need; this is an issue which has been of concern to legal workers (Gostin,1979a; Gordon,1980).

The assumed competency of mental health staff must also be considered, not because of any individual shortcomings but because of the general uncertainty surrounding the practice of psychiatric medicine. The issue has, of course, been extensively discussed and, as I pointed out in Chapter 2, tends to be one of the forces propelling the mental health law movement. As Anand has argued (1979), the concept of mental illness is as problematic as presumptions of psychiatric expertise. "Psychiatric diagnoses using the accepted diagnostic categories have been found to be both unreliable and invalid" (op cit:270) whilst attendant treatments may be little more than attempts to control or change unacceptable behaviour by coercion (op cit). Given more recent developments in the standardisation of psychiatric diagnoses, this may be an unduly harsh critism.[5] However, in the context of treatment rather than diagnosis, it still seems that despite such advances, psychiatry appears to be more a science of symptom suppression than disease eradication. Indeed it could be argued that, in the psychiatric context, many patients may be better healers than their physicians; a possibility that seems to underlie certain treatment modalities (e.g. some forms of psycho-therapy). Thus in the context of determining what is in the 'best interests' of a patient, the employment of the general notion of 'competency' as a measure of the legitimacy of any judgement does not rest on a sound base.

Similar doubt can be cast on the assumption that a predictive 'equation', or some ultimate state of knowledge, exists in an accessible form (Goldstein, et al,1973). Indeed such hubris invests both psychiatrists and lawyers with powers of prediction that have been traditionally associated with the gods. If 'objective' criteria exist, for example in the form of 'laws' governing human and social conduct, they have, in the main, evaded exposure. Configurations of circumstances and alternative courses of action may not, therefore, necessarily lead to the assumed or predicted outcomes. Intervening or contaminating variables can distort a perception of outcome and frustrate a planned goal. As Goldstein, et al, point out (1973), in the context of legal judgements,

> "...too frequently there is attributed to law and its agents a magical power - a power to do what is far beyond its means...(I)t does not have the capacity to predict future events and needs, which would justify or make workable over the long run any specific conditions it might impose..." (op cit:50)

It is a situation equally applicable to psychiatry.

In addition, no objectively determinable conclusions can exist for assessing benefit and loss associated with outcome necessarily involves the application of values. Certainly some form of consensus may seem to exist in relation to certain outcomes in certain circumstances. For example, to employ a rather familiar issue, if the saving of a person's life was dependent upon blood transfusions then clearly the acceptance of such transfusions might be widely acknowledged as a desirable goal. However even here a divergence of opinion may exist. Disagreement may be based on, for example religious grounds, such that the 'best' conclusion cannot be assumed to be an immutable and non-contentious entity.

Indeed this type of issue has been raised in a recent case in the United States. In Re Boyd,[6] a matter involving treatment given to a Christian Scientist patient involuntarily committed to a mental hospital, the court acknowledged the probability of a patient holding a legitimate perception of 'best interests' at odds with that held by a hospital. As such they attempted to provide guidelines (by way of the doctrine of substitute judgement) that recognised a divergence of opinion. In this respect they ruled that any decision concerning treatment must be based on a determination of what the patient would have done had she been competent, rather than what a hospital believes would serve the patient's 'best interests'. The judgement may open another Pandora's Box but at least it challenges the notion that 'experts' or 'professionals', notably psychiatrists, are able to determine what is in a patient's 'best interests'.

To a certain extent these issues have been overdrawn. Whilst it is quite possible to fall into a relativist abyss when handling the topic it has been necessary to briefly approach the brink in order to highlight the virtual impossibility of objectively applying the notion of 'best interests' as it is currently conceived (Goldstein,_et al_,1973). The term implies that an individual's interests can be recognised and served by another, independent of the subject's contribution. Without such a contribution, however, the 'judge' must necessarily apply his or her own perception of a desired goal and then attempt to act upon it. Controls may be placed on the exercise of such a power by assuming that the 'protected' person would wish to preserve certain assets, for example, life, limb and property, but, other than these broad parameters, a 'best interests' judgement necessarily involves an application of the personal judgement of another. Perceptions of what is needed or what needs to be done, as an expression of a patient/client's image of what is in his or her 'best interests', may not accord with that held by the individual wielding the power to control decision-making. In this situation, the patient becomes something of a pawn obliged to accept the premise that another appreciates his or her interests and his or her perception of what is 'best'.

In the context of a conflict between competing perceptions of need, or perceptions of what is in the 'best interests' of a patient, the pawn's vulnerability is complete. As I have suggested it is no safer to assume that, in the mental health context, a lawyer representing a patient is acting in the patient's 'best interests'. As Stone has argued,

> "Legal advocates for the mentally ill have not been willing to consider seriously the needs of the mentally ill and to formulate those needs as legal rights. Instead they have done the reverse. They have treated rights as if they constituted the needs of the mentally ill."(1979b:820)

Conversely, as Kopolow argues,

> "Paternalistic practices in public and private facilities have often resulted in violation of many basic legal and human rights under the argument that such actions were necessary for the patient's welfare. Failure to adequately respect the rights of non-dangerous individuals to live a life free from medically imposed standards of mental health have led to psychiatry being viewed by many patients as an oppressive force acting as agents of Government policy of isolating and controlling all forms of social deviance..."(1979:263)

On the one hand, the lawyer is accused of holding incorrect perceptions of patients' needs whilst, on the other hand, the same allegation is levelled at psychiatrists. In such a scenario the patient, it seems, confronts a two-edged sword honed on the grinding face of conflict between two professional groups both of which assume they are acting in the patient's 'best interests'.

It is worth noting that the dilemma is additionally confused by the diversity of opinion that appears to exist amongst mental health professionals; both Kopolow and Stone, cited above, are psychiatrists. Thus a certain lack of uniformity and consistency exists in relation to psychiatric-centred perceptions of patients' needs. However, as I pointed out in Chapter 2, in general a substantial psychiatric lobby has formed as a reaction to the patients rights 'movement', building its position around the so-called 'over-reach' of mental health lawyers. Such over-reach, it is argued, has led to 'benign neglect' (Schmolling,1975; Sehdev,1976), an exchange of the 'back wards' for the 'back streets' (Whitner,1980; Wald & Friedman, 1978; Scull,1977; Roth,1979), a process of patients 'rotting with their rights on' (Rachlin,1975; Appelbaum & Guthiel,1979), and the 'criminalisation' of mental illness (Abramson,1972; Whitmer,1980; Stelovich,1979). The vigorous and sometimes vitriolic debates that have ensued[7] have, inter alia, tended to expose and to some extent crystalise, the various psychiatric-centred perceptions of patient need which had hitherto lain dormant possibly at the 'expense' of the health needs of patients (Stone,1979). This process has not, however, necessarily clarified the overall picture.

Perhaps because of the uncertainty that surrounds the practice of psychiatry, the actual health needs of patients are unclear and difficult to define (Hafner,1979; Mental Health Planning Survey,1979; Fryer,1979). Although, as Hafner argues (1979), needs in the mental health context appear to involve simply "an undesirable situation and the possibility of remedy" (op cit:3), the locus of the definition is unquestionably relevant (Fryers,1979). Thus, as is the case in relation to legal needs, the determination of health needs depends entirely on "whose needs are being considered by whom" (Fryers,1979:58). Needs can be defined in a national, group or individual context (Ibid) and, in the last instance, can be arranged on a continuum between the needs of severe or chronic cases, to the needs of those confronting "harmless life crises" (Hafner,1979:6). Further, perceptions of need in a psychiatric context will be influenced by the stance adopted by the practitioner in relation to the substance and treatment of mental illness. The perceptions of health needs held by Ronald Laing (1967) or Thomas Szasz (1961,1965) are markedly different from those held by a substantial proportion of practising psychiatrists.[8]

Given this somewhat complex situation it is not suprising to find a divergence of views in different treatment settings. Mental health professionals working in community health centres seem to hold different perceptions of need than those working in institutions. In the community treatment setting, it has been argued that health needs are interwoven with a complete range of 'social' service needs complementing the process of 'normalisation'. Such needs include the need for legal services (Klein & Goldston,1977; Errion & Moen,1976; Mental Health Planning Survey,1979; Weihoffen,1969) a view that seems to be generally supported up to the point where needs in a legal context are re-defined as enforceable rights. However, it is also apparent that where the 'rights' involve needs that complement the perception of need held by mental health professionals, opposition to the determination and enforcement of rights is absent. For example, where zoning restrictions in municipalities have been applied to obstruct the development of community treatment alternatives (notably the concept of the half-way house) then a distinctly unified approach is apparent (Talbott,1980; Cupaiuolo, 1977; Elpers,1978). Where a 'common' problem is not present the use of legal resources for the resolution of disputes is opposed. Indeed it is clear that the process of 'double-think' allegedly found amongst mental health lawyers who agitate for patients' rights (Appelbaum & Guthiel,1979) may also be present amongst mental health professionals.

However, this process of selective support really only reflects a perception of need that has a different scale of priorities. As Sadoff & Kopolow have pointed out (in Kopolow & Bloom,1977), the psychiatrist is primarily a physician, utilising the medical model when dealing with his or her patients. As such he or she is raised on the tradition that in applying medical skills and techniques to the best of his or her ability, on behalf of a patient, he or she is both acting in the patient's 'best interests' and discharging a legal and ethical duty to the patient. "He (or she) has no selfish interest in keeping the mentally ill hospitalised against their will, save for their own good. He (or she) is concerned about life and health before liberty"(op cit:37).

This perspective and the attendant conflict with lawyer-centred perceptions of need is more clearly articulated in the following, familiar litany.

> "For the ill person, physically or mentally, health has the highest priority, for what freedom is there when one is trapped within his own physically ill or mentally ill body? When the concepts of health and freedom conflict, the lawyer may still choose to free his ill client regardless of consequences, but the psychiatrist, as a true advocate of the total person, must be more cautious and allow his patient to go free only when he is ready to go and will not, because of his mental illness, harm himself or others." (op cit:38)

For some patients, however, 'freedom' may not be a tenable condition at any time. Because of their 'illness' it may not be in their 'best interests' to live independently in the community. As Schmolling argues,

> "Many retardates, senile persons, and regressed schizophrenics are unable to function in the community and require special care. Indeed, some of them need help with the most elementary activities of daily living such as eating, dressing and bathing...In my view the majority of patients in our mental hospitals...really are helpless, weak, sick and incapacitated in varying degrees,...most patients have genuine impairments that make it difficult for them to maintaim themselves in the community."(1975:169)

As Scull has noted (1977), it is this group who suffer most from the effects of a policy of 'decarceration' without the complementary provision of effective community-based alternatives.[9] For this class of patients the psychiatric-centred perception of need involves an emphasis on lodgement and care in safe surroundings rather than the pursuit of 'cure', per se.

The restoration of health and the provision of care prior to such a condition are, therefore, seen as the principal objectives of the psychiatrist; objectives that must take precedence over liberty. This is not to suggest that freedom is not perceived as a desirable goal but, rather, that for the mental health patient only clinically determined 'good' health is the equivalent of true liberty. The perspective assumes that the objectives are shared by patients and that, in working to achieve the objectives, psychiatrists are acting in the 'best interests' of a patient. The patient needs restored 'health' and proper care prior to that happy condition but only a treating psychiatrist is able to determine when that need is satisfied.

The dispute, then, may not revolve around the concept of freedom or liberty, <u>per se</u>, but, rather, conflicting views of what the concept means; that is, what constitutes 'true' freedom or liberty. In this scenario the tyranny of the 'best interests' judgement seems to flourish. This issue, of course, forms the locus of critiques of the mental health system discussed earlier and revolves around the disputed assumption that psychiatric treatment will effectively restore health and therefore liberty.

In addition, it is also necessary to consider that psychiatric-centred perceptions of need are coloured by 'responsibilities' placed on mental health professionals in the 'social control' context. That is, whilst their principal concern must be for the health needs of a patient they are also required to consider the need of the community at large to be 'protected' from harm at the hands of a patient. As Weisstub notes,

> "Every sovereign state possesses the power to legislate to protect the health, welfare and safety of the public. Civil commitment, when utilised to protect society rather than the mentally ill person, constitutes an exercise of the power in the public interest (called an exercise of the police power in the United States)...The main state interest involved is the need to protect the public from persons who are thought to be mentally disordered and dangerous to others."(1980:333)

Herein lies the vexed issue of 'dangerousness' and the problems involved in predicting future behaviour especially in the criminal law context (see, in general, Weisstub,1980; Allen,*et al*,1975; Brakel & Rock,1971). Although germane to a complete discussion of the conflicts between perceptions of need in the broadest sense, this general issue is not central to an understanding of psychiatric-centred perceptions of *patients'* needs. As such it will be by-passed although with the *caveat* that where a patient may be perceived to be harmful or dangerous to him/herself then clearly the issue is pertinent. However, in this situation the problem can be, I would argue, successfully collapsed into the principal objectives already outlined. That is, the issue of dangerousness can be tied to the goal of restoring health (for dangerousness to self implies ill-health) and, prior to that condition, the provision of care (which can involve providing secure surroundings where dangerousness to self is suspected).

The '*leit-motif*' of psychiatric-centred perceptions of patients' needs is, therefore, the provision of care and the restoration of health and, as a corollary, the unhampered and therefore effective, employment of treatment that will attain such a goal. Even forced treatment will be, later, appreciated by a patient and acknowledged as having been in his or her 'best interests' (Shone,1976; Katz,1970; Appelbaum & Guthiel,1979). Those who oppose the processes by which such a goal can be satisfied are accused of a failure to consider "clinical realities" and, despite some evidence that arises to the contrary (Opler,et al,1980), of holding misconceptions in relation to the effectiveness of different treatment modalities (Appelbaum & Guthiel,1979). Where this perception of need is challenged, the protagonists are accused of "misinterpreting" need (Stelovich,1979), stifling "innovative developments" (Stickney,1974), encouraging a return to "Gothic treatment practices" (Armstrong,1978), hampering the employment of therapies that might lead to a rapid restoration of health (Armstrong,1978; Bachrach,1980; Appelbaum & Guthiel, 1979; Talbott,1980), and failing to acknowledge the legitimacy of a 'caring' approach to patients' needs (Talbott,1980).

This is not to suggest, however, that the situation is characterised only by conflict. As I noted in Chapter 2, mental health professionals have come to recognise that many of the rights pursued by mental health reformers in fact complement their own perceptions of patient need (Davis,1978). Indeed, psychiatrists have been active in supporting, if not actually instigating, some of the litigation in the United States that has generated the reforms criticised by other mental health professionals. Thus, whilst on the one hand certain groups of psychiatrists have responded with indignation to what they perceive to be encroachments on their right to provide effective treatment (Reinert,1979; Schmolling,1975; Talbott,1978; Appelbaum & Guthiel, 1979; Katz,1970; Armstrong,1978), others have recognised the importance of a certain unity in the face of a common foe; namely governments (Greenblatt,1974; Hansen,1975).

In an investigation of the impact of programmes designed to provide less restricitive treatment settings in the United States a Nader team found that, although 'warehousing' had been condemned, the numbers of people in hospitals had not been drastically reduced (Chu & Trotter,1974). A process of "innovation without change" had occurred, the fault for this development lying with governments who had failed to provide the necessary resources (notably financial) to give effect to the innovations (Scull,1977). This complaint has been echoed by Greenblatt(1974), the former Massachusetts Commissioner of Mental Health, who, prior to a mental health class action, claimed he had been trying for several years to change conditions in state mental hospitals. A lack of funds had been advanced as the rationale for not implementing necessary changes and, as he argued, it was only through court action that the government were finally forced to direct additional money into the state mental health system.[10] Similarly, Hansen has argued (1975) that the interests of mental health professionals and 'civil liberties' lawyers are basically the same. Where difficulties arise in giving effect to court rulings the problem can be, invariably, traced to unresponsive government agencies who are reluctant to finance reforms (Rubin,1978; Steadman,1979a). In the United States context this issue raises, as Wald & Friedman point out (1978), the question of whether courts (particularly federal courts) should or do, have the power to direct fiscal policies in a state; a matter deserving a separate treatment. However, the main point to be drawn from the overall debate is that, in many areas of apparent conflict between perceptions of need, the actual 'villain' may be an indifferent government that has set a low priority on general, mental health system needs, rather than one particular group of professionals.

In summary, it can be argued that although the conflict between health needs and legal (notably civil rights) needs is central to an understanding of the tumult affecting mental health reform, the line between the two 'competing' groups is far from clear. Indeed it seems they may well, as Chodoff has noted (1976), be both in pursuit of the same basic objective but hold competing views as to how this may be achieved. In addition it is clear that priorities may be different. As Yake has noted,

> "A dichotomy seems to exist between the philosophy of the doctor who wants to preserve human life and lawyers who are concerned with personal liberty and justice... The medical profession views best interests of the patient as synonymous with possible benefit from treatment even under duress, while the legal profession perceives liberty in terms of the individual exercising his freedom to behave as he wishes even if under duress of illness." (1976:24).

For the mental health professional, liberty is equated with restored health as defined in a clinical context. For the mental health lawyer liberty seems to be an absolute condition independent of medical determination, principally because of the unreliability of the latter.

Perhaps the tragedy lies in the fact that, whilst we have evidence of conflicts between competing perceptions, we have no clear evidence to indicate whether there is necessarily a conflict between the actual content of the needs as advanced by the different groups. It is conceivable that an effective compromise, amenable to research and independent of the ideologies associated with each group, exists. Such a compromise is one in which both health and civil rights needs can be effectively answered. As Wald & Friedman suggest (1978), patients could well be the victims of internecine warfare between professionals, a state of affairs that will be undermining the very goals sought for patients by all three groups - liberty and health. Similarly, as Kopolow has argued,

> "The defensiveness of psychiatrists and their inability to acknowledge past and present abuses of mental health care among their colleagues have denied patients the assistance of the one group that has traditionally advocated improved care for the mentally ill. It has also resulted in their becoming excellent scapegoats." (1979:263)

To a possibility of internecine rivalry one can therefore add the possibility of internecine stubbornness.

As several writers have noted (Polier,1968; Stone,1975; Meehl in Monahan,1975; Brooks,1974; Burris,1969) there appears to be a profound, underlying, ideological conflict between lawyers and mental health professionals, neither side having a monopoly on truth. Whilst the hegemony of psychiatrists may be a real phenomenon worthy of criticism, exchanging it for the hegemony of lawyers may be equally questionable. This is particularly true where the needs of patients become a secondary issue in a tustle for power between two stubborn, rival groups.

As Polier has noted (1968), a product of this conflict is an absurd stereotyping of each group by the other. On the one hand, lawyers seem to perceive psychiatrists as either, "eminent and reluctant dragons who will do anything to avoid court appearance...or those who will come to court and whose testimony can be contradicted." On the other hand, psychiatrists seem to perceive a lawyer as "...a necessary evil who takes care of leases, wills and marriages...a person who demands yes/no answers to impossible hypothetical questions at an investigation of a man's sanity and a person who engages in a vigorous attack regardless of what is good for his client."(op cit:5-6) If such a rift between lawyers and psychiatrists is a real and current entity, it may help to explain the apparent inability of the two groups to recognise and accentuate the mutualities in their perceptions of patients' needs, to the ultimate benefit of patients. As it stands, any rift created as a function of inter-profession rivalry or tension rather than as a function of competing perceptions of need, per se, may be perpetuated at the expense of patients. Their needs may be a somewhat distant concern in the context of a battle between two groups purporting to be concerned with patients' 'best interests'. This suggests that where confusion exists in relation to the point at which patient need is answered perhaps the final and only arbiter must be the consumer floating in the vacuum created by the abused concept of 'best interests'. In this respect the clients' perception of need must be thoroughly understood.

Research on 'client or patient-centred' perceptions of need has, as I have indicated, been rather limited. It is argued that this is a function of two, probably questionable, assumptions about the client group. Firstly they are incapable, by virtue of their illness, of conceptualising and articulating their needs, and, secondly that, in keeping with beliefs in relation to disadvantaged people in general, they are unable to properly recognise needs in a legal or medical context. Both assumptions are somewhat undermined by the work of those researchers who have, in the first case, canvassed the opinions of mental health patients and, in the second case, tested the extent to which legal and medical 'consciousness' is held by various disadvantaged groups.

It is apparent that whilst some patients diagnosed as chronically schizophrenic may be incapable of comprehending information, appreciating the legal consequences of their actions and determining what is ~~in~~ their 'best interests' (Grossman & Summers,1980;[11]Mason, *et al*,1978) other types of patients can have a clear conception of needs and an ability to evaluate the extent to which services offered to them are useful or satisfactory (Fryers,1979; Nuehring, 1979; Koltuv,et al,1978; Swearingen & Thompson,1978). In the specific context of legal services, it is also possible to see that it is perfectly feasible to conduct research with mental health patients and that, in the main, they are able to articulate their requirements (Epstein & Lowinger, 1975; Brakel,1978).[12] Given the fact that, in the medical and legal contexts, patients are frequently excellent advocates on their own behalf, both as individuals (see, Patient A25738, in Burris,1969; Lottman,1977; Standing Social Development Committee, Garcia,1977) and as a 'consumer group' (Kopolow, 1979; Kopolow & Bloom,1977; Standing Social Development Committee,1978) this revelation should come as no suprise.

In this respect the patients' perspective of health needs can be determined from an analysis of the 'Charters' of patients' rights advanced by the various emerging consumer groups. As Kopolow notes,

> "The increasing scrutiny of psychiatric practice by outside forces is not occurring in isolation, but rather, is part of a far broader consumer movement seeking higher standards of accountability from all providers of services..."(1979:263)

In this context, the advancement of patients' perceptions of health needs may generate conflict with mental health professionals although this is not an automatic outcome. Indeed, as is perhaps the case with conflicts between lawyers and psychiatrists, there appears to be a certain mutuality in relation to the major objectives - health and liberty - but a disagreement over what this means and how this is to be attained.

As Kopolow notes(1979), many patients' organisations have developed in recent years some of which have been successful in influencing legislative reform. (see, also, Standing Social Development Committee,1978; Kopolow & Bloom, 1977). Expressed as rights, the health needs perceived by such groups can be summarised as follows:

1) The right to be treated with dignity and respect.
2) The right to freedom from unnecessary hospitalisation.
3) The right to complete freedom from unnecessary treatment.
4) The right to information about treatment.
5) The right to confidentiality in the doctor/patient relationship.
6) The right to services of sufficient quality to encourage improvement of health.
7) The right to receive mental health services when and where they are needed.
8) The right to a guaranteed opportunity for patients to participate in treatment decisions which affect them and to be actively involved in the establishment of priorities.

9) The right to redress for grievances.

10) The right to advocacy to assure that patients are getting appropriate and humane treatment. (Kopolow,1979:267-268)

Clearly, whilst some of these 'rights' may be at odds with the perception of need held by mental health professionals, there are also noticeable similarities. In listing patients' rights as perceived by such professionals, Davis (1978) provides a useful comparative tool with which to explore the issue. He argues that patients should have the following.

a. A right to alternatives to hospitalisation (see 2) above).

b. A right to receive treatment from an array of staff (see 5) and 7) above).

c. A right to a diversity of treatment modalities (see 6) and 7) above).

d. A right to physical as well as psychiatric examination (see 6) above).

e. A right to a clean, attractive and pleasant environment (see 6) and 7) above).

f. A right to one staff member as an advocate (see 9) and 10) above).

g. A right to appropriate psychotropic medicine (see 3) and 6) above).

h. A right to follow up after hospitalisation.

Based on this limited comparison it would seem that, in the main, very few differences may actually exist. Perhaps the area most likely to cause conflict lies in the context of a right to be involved in decisions pertaining to treatment. As Daugherty has noted (1978) the patients' rights that receive the least support from mental health professionals are those that require the attribution of responsibility and judgement to a patient; a phenomenon tied directly to the problematic concepts of competency and 'best interests' decision-making.

In the context of perceptions of legal need, the comparison provided above demonstrates some further mutuality. Both groups - patients and mental health professionals - appear to acknowledge the need for some type of 'advocacy' although as Kopolow & Bloom point out (1977) the actual form this advocacy should take has been, and is, subject to extensive debate. On the one hand, 'advocacy' is seen in a non-conflictual, 'helping' context, a legal component only arising where a 'common' foe is identified (e.g. a recalcitrant mental health authority). Disputes or disagreements involving the health needs of patients are best dealt with by essentially 'administrative' negotiations, an advocate serving as a form of ombudsman (Kopolow & Bloom,1977; Stone,1975). On the other hand, it is argued, an effective pursuit of patients' needs and interests can only be achieved by recourse to a partisan, advocacy approach that involves an adversarial context following conventional lines of controlled conflict (Gostin & Rassaby,1980; Kopolow & Bloom 1977; Anand,1979; Brakel,1977; Ennis & Siegel,1973; Ennis, et al,1974). Such a dispute, again, involves competing perceptions of patients' needs and what is in the patients' 'best interests'. Fortunately, some material is available which helps to clarify the patients' perspective.

The two studies on patients' perceptions of legal need and the materials that examine the work of mental health 'consumer groups', demonstrate a certain capacity amongst patients to recognise when their needs can be best served by some form of legal assistance. This phenomenon has also been found during studies of unmet legal need among other 'disadvantaged' groups. In a test of White's contention (Morris,et al,1973) that one reason for the non-use of legal resources is a failure to recognise a problem as 'legal', my own research in Melbourne (Bothmann & Gordon,1979) indicated that "not perceiving a problem as 'legal' in the first instance is less of a problem than the barriers to actually using a legal resource"(op cit:33).[13] This tended to confirm the results of other studies in Australia, England and the United States (Zander,1978) which, collectively, highlighted the problem of how best to serve realised but unmet legal need, as well as the issue of raising the level of public, legal 'consciousness'. Because potential clients were found to be alienated from legal resources and services, preferring to seek out other, more familiar or less formidable agencies before trying to obtain direct legal assistance, considerable impetus was and is, given to legal aid delivery modes that emphasise; a) non-alienating premises and staff (e.g. 'store-front' offices); and b) the development of a network of community contacts that could effectively channel clients.

It is thus apparent that by not attempting to determine the client/patient's perspective of legal need and the most appropriate method of answering that need, an unjustifiable vacuum exists in our knowledge of how best to serve the interests of patients(Brakel,1978). As Wilson, et al, have pointed out (in Kopolow & Bloom,1977),

> "...advocacy programs which have been developed are too often based on the perceptions of the providors (sic) of care and of legal services and not on the articulated needs of the clients they serve."(op cit:8)

However, this is offset by the results of the few evaluations that have been undertaken of mental health patients' legal services and the more general accounts of the operations of such services. These examinations provide an opportunity to understand what it is that clients/patients demand (or perhaps, seek out) when they have access to legal resources and therefore to determine the 'leit-motif' of their perception of legal need. It should be noted, however, that such sources may not be absolutely reflective of the clients' perspective given the possibility that, even in a legal aid delivery setting where the opportunity for client power in the lawyer-client relationship is supposed to be maximised, a certain amount of lawyer manipulation of clients may still occur (Bothmann & Gordon,1979). This possibility will be discussed later in this chapter in the context of the conflict of roles confronting legal workers.

To perhaps dispel any such doubt, it is useful to consider the perceptions of legal need advanced by patients' groups. Just as they have (as indicated above) offered their perceptions of health needs by way of 'Charters of Rights' so too have they included legal needs in such Charters. Indeed, by attempting to have their needs defined and legislatively enshrined as 'rights' they are demonstrating a persistent legal need. Namely, the need for access to resources that can assist in advancing needs as rights before legislators (i.e. relevant committees) and courts.

A useful example of this wider perception of legal need and of a list of more specific legal needs is provided by the testimony of the Ontario Mental Patients Association, before the Ontario Standing Social Development Committee (1978) reviewing the provincial <u>Mental Health Act</u>. The twenty-two point 'Bill of Patients' Rights' presented by this group included many of the main themes outlined earlier in the specific context of health needs. Thus, they demanded a right to information about treatment; a right to be treated with dignity and respect; a right to adequate and immediate medical treatment from the doctor of their choice; a right to an alternative to a mental hospital; the right to decent, humane, living conditions whilst in hospital; and a right to confidentiality. They also argued for rights of a more specifically 'legal' nature.

In this respect, fourteen items pertained either directly to the types of needs that could be answered, in a mechanical sense, by legal services or involved issues that could be effectively pursued by such an agency. In relation to the former, the Bill of Rights included, i) the right to legal counsel who would represent patients' interests, as defined by patients, particularly during initial and subsequent psychiatric interviews; ii) the right to an automatic hearing by an *ad hoc* committee for all people facing commitment;[14] and iii) the right to sue any psychiatric institution or staff.

In the context of issues that could be pursued by a legal service, the Bill of Rights included, i) the right to refuse treatment; ii) the right to uncensored communication; iii) the right to equitable pay for work performed while in hospital; iv) the right to financial assistance while in hospital; v) the right to be provided with adequate income and housing on leaving hospital; vi) the right to organise patients' groups in hospital; vii) the right to be provided with nutritious and adequate food while in hospital; viii) the right to be involved in decision-making at all levels of the institution; ix) the right to vote in any elections; x) the abolition of involuntary commitment; and xi) the right to choose and consult with any doctor or therapist not affiliated with the institution. In addition, the Bill included a requirement that it be a part of the relevant mental health legislation and that the relevant government bodies consult regularly with patients' organisations regarding any abuse or violation of rights and any abuses of treatment that may occur in institutions.

It will be noted that many of these rights correspond with the types of issues already pursued in the context of poverty law. Similarly, others fall into a category of institution or treatment-related matters that have been associated with mental health law. In both cases, a clear picture is presented of the perception of patients' legal needs as held by patients' organisations. Although, in all probability, such organisations truly represent their consitituency's wishes it is still necessary to question whether or not the needs that are advanced are truly reflective of those held by individual patients. In this respect, some research is available to assist the enquiry.

Several studies have attempted to provide a taxonomy of client needs in both institutional and community health centre settings (Bothmann & Gordon,1979; Brakel,1978; Dickey & Remington,1976; Coye & Clifford,1978; Weihoffen,1969; Strand,1972; Rappaport,1974; Steadman & Brooks,1977; Johnson & Aanes,1974; Jansen & Krause,1974; Broderick,1973; Garcia,1977; Gostin & Rassaby,1980; Huey,1975).[15] It is clear from this work that whilst two broad categories of legal need exist - one pertaining specifically to their situation as institutionalised people and the other falling into the general area of poverty law - mental health patients are principally concerned with the need to be rid of the institution (Epstein & Lowinger,1975; Brakel,1978; Dickey & Remington,1976). As Brakel puts it, "(i)t is clear from (the responses) that thoughts and activities relative to discharge...are an overwhelming reality in the lives of most of the institutionalised..." (op cit:576); a finding that confirmed the results of an earlier study by Epstein & Lowinger (1975).[16] This, then, is the principal theme or '<u>leit-motif</u>' of the institutionalised patient's perception of legal need and it is apparent that the usefulness of a legal service is measured by the extent to which it is prepared to pursue this need on behalf of patients; that is, the extent to which it answers the unmet need.

Closely connected with this central issue, but still within the context of institution-related problems, are a plethora of other matters involving the restraints on certain civil rights that arise as a consequence of institutionalisation, disputes or dissatisfaction with treatment programmes, disagreements with staff and other patients, invasions of privacy, and the loss of 'privileges'(Brakel,1978). Similarly, patients appear to perceive legal solutions to problems that might arise for them following discharge from the institution; notably the avoidance of stigma, securing suitable employment, recovering basic civil rights (e.g. the right to vote or hold public office) and regaining control over their estate (i.e. being re-classified as 'competent' persons and thereby overcoming the control exercised by a Public Trustee or similar body) (Brakel,1978; Dickey & Remington,1976).

In the context of more conventional 'poverty law' matters, patients perceive legal need and request legal services in relation to creditor problems, family law and ancilliary matters, housing, government benefits (social welfare law), wages and employment, recovering money owed to them, taxation problems, and immigration matters. As these are seen as the conventional province of lawyers, patients appear to have little difficulty in recognising the relevance of legal services in answering such needs, particularly where 'court' action is seen to be a normal aspect of the resolution of such problems. These needs may arise as a result of the process of institutionalisation,[17] during incarceration,[18] or prior to discharge to a community treatment setting.[19] As some writers have argued (e.g. Rappaport,1974) the needs may even have arisen prior to the onset of illness and, in some cases, may be if not causal, then possibly relevant to, the actual illness itself.[20] In this respect, rapid resolution of the problem may assist therapy and encourage a speedier recovery leading to discharge, benefits accruing not only for the patient but also for the mental health system itself (Dickey & Remington,1976).

However, unlike the situation in 'conventional' poverty law settings, actually dealing with such legal needs may be confounded by the legal 'status' of the client as mental health patient. The issues of legal 'capacity' (or standing) and 'competency' are complex and central to all areas of activity in both public and private law. As such they have been extensively examined in the English (Venables,1975), Canadian (Price,1973; Weisstub,1980) and United States contexts (Brakel & Rock,1971; Allen, et al,1975). Suffice it to say that three matters are pertinent to the delivery of legal services:

1) whether or not an action can be taken in the name of a person who may suffer from mental incapacity;
2) whether or not a person can be spared the consequences of their actions because of mental incapacity; and
3) whether or not a person can be prevented from acting or have prior actions invalidated because of mental incapacity. (Price,1973)

No consistent 'test' of capacity applies to the overall pursuit of legal actions (Weisstub,1980), each area of law offering its own criteria developed through common law. In general, however, restraints may be placed on actions in such areas as contract, tort liability, marriage, divorce and custody, and Wills, serving to both frustrate and protect a client/patient. The issue of capacity can be, on the one hand, "a sword with which to attack an individual," and on the other hand, "a shield with which to protect" (Price,1973). For a mental health patient and his or her lawyer it can also be a sizeable millstone.

In the main, it appears that many of the needs (in both the legal and medical contexts) as perceived by individual clients coalesce with those advanced by patients' organisations. There are no apparent areas of conflict and where the perceptions of need advanced by patients' organisations do not seem to be sufficiently extensive this may be due to the need for them to be condensed into compact 'Bills of Rights'. In addition, it is also clear that the needs advanced by both patients and patients' organisations correspond with 'lawyer-centred' perceptions of client/patient need. As my earlier discussion of developments in mental health law will have indicated, lawyers have been energetic, particularly in United States jurisdictions, in pursuing patients' rights; that is, dealing with the institution-related needs. In this respect they have endorsed the patients' pressing concern for release from an institution. In addition, they have also been concerned with broader issues which, whilst pertaining directly to patients' interests and patients' rights have a wider impact and significance.

Probably in the sincere belief that they were (and are) acting in the 'best interests' of both individual clients and the client group, mental health lawyers in both Commonwealth and United States jurisdictions have used their 'expert' knowledge and skills in the pursuit of numerous reforms. They have sought such things as shorter periods of hospitalisation, the requirement of periodic review (judicial and otherwise), the right to appointed counsel in commitment hearings, the introduction of specific standards of behaviour to justify commitment (an issue entwined with the problem of determining dangerousness), certain rights in pre or post commitment hearings, and a separation of procedures for commitment and determining competency (Strand,1972; Standing Social Development Committee,1978; Gostin & Rassaby,1980; Institute of Criminology,1978; Ennis & Siegel,1973; Ennis, et al,1974; Sharpe,1980; Roth,1979,1980; Note,1967; Note,1975; Kumasaka & Gupta, 1972; Green,1979; James,1978; Cohen,1966; Andalman & Chambers,1974).[21]

Whilst such matters are, clearly, important having a special bearing on the construction of a mental health system that is both humane, effective and, at the same time, a respecter of civil rights in a democracy, they involve complex issues that may not be perceived as needs by individual clients experiencing the immediacy of mental health treatment programmes. In this sense it could be argued that such activities really represent nothing more than a revitalisation of the old doctrine of <ins>parens</ins> <ins>patriae</ins> and its attendant paternalism. The 'new' mental health lawyers acting as 'partisan advocates' in the 'best interests' of patients are simply replacing public officials who used to attempt to carry out the same role but with a different ideological perspective, namely an adherence to a 'medical' rather than 'legal' perception of 'best interests'.

It must be noted, of course, that where 'lawyer-centred' perceptions of need have involved effecting changes within institutions, it can be argued that they are following a '<ins>leit-motif</ins>' consistent with that professed by patients/clients and their organisations. Attempts to introduce such things as new review procedures, community alternatives to the institution, improvements in physical plant and staffing ratios, controls on the abrogation of basic civil rights, fair remuneration for work undertaken for the institution, and controls on treatment modalities (in particular, the use of E.C.T. and the various forms of psycho-surgery as well as the over-use of chemo-therapy), can be seen to have direct relevance to individual patients. Herein, it will be noted, rests the full range of issues pursued and discussed by mental health lawyers and others, notably, the right to treatment (Burris,1969; Bazelon, 1969; Ennis,<ins>et</ins> <ins>al</ins>,1974; Farmer,1967; Greenblatt,1974; Stone,1975; Stickney,1974; Rubin,1978; Schwartz,1974;

Morris,1970, McGough & Carmichael,1977),[22] the right to refuse treatment (Appelbaum & Guthiel,1979; Armstrong, 1978; Bradley & Clarke,1976; Clayton,1976; Ennis & Siegel,1973; Ennis, _et al_,1974; Rubin,1978; Farmer,1967; Golann & Fremouw,1976; Stone,1975; McGough & Carmichael,1977),[23] the right to the least restrictive treatment setting (Bachrach,1980; Clayton,1976; Ennis, _et al_,1974; Golann & Fremouw,1976; Rubin,1978; Stone,1975; Lamb,1979; Kindred, _et al_,1976),[24] the right to compensation in return for hospital employment (Armstrong,1976,1977; Rubin,1978; Editorial,1976; Schwartz,1976; Safier,1976; Stone,1975; Brakel & Rock,1971; Szasz,1977),[25] and other concerns of apparent, direct benefit to individual patients as well as the community of mental health patients.[26]

In this context, it is possible to see a substantial redefinition of 'needs' into 'rights', the vigorous pursuit of which, as I have pointed out, has generated criticism on the part of some mental health professionals concerned with the issue of whether or not the establishment and enforcement of such rights are truly in the 'best interests' of patients.

As has been noted, considerable effort has been made to improve, for example, the procedures by which a patient comes to be involuntarily institutionalised, by employing an existing right to 'due process' before liberty is restrained. In this area, the concern appears to be directed at future generations of patients and the ~~broader~~ issue of protecting the community from arbitrary curtailments of liberty rather than answering the needs of patients who are already institutionalised. However, this is not to suggest that lawyers are insensitive to the needs of individual patients, but, rather, that such patients may become useful vehicles through which to pursue grander schemes to the ultimate benefit of the future 'community' of mental health patients.

The rationale for such an approach is, of course, that the relevant activities are being undertaken in the 'best interests' of mental health patients. As such, lawyers may be as prone to a questionable utilisation of the concept as psychiatrists. Certainly it must be acknowledged that in many instances the 'best interests' judgement is founded upon instructions received from clients and, in particular, patients' groups. However, it is also possible that because of their occupationally determined '_weltanschaaung_' and specific ideological commitments or preferences (e.g. the vigorous pursuit of civil rights) lawyers receiving such 'briefs' dictate the direction and appropriateness of a given course of action such that it benefits the evolution of the somewhat abstract body known as mental health law. In such instances there can be a considerable gulf between what a patient may perceive to be a problem and a solution and that which a lawyer recognises as a possible 'milestone' or 'bellwether' case in a continuing evolutionary process, providing the problem and solution can be redefined for the patient/client. Although no evidence exists to indicate the frequency and distribution of this phenomenon, it has been raised as a problem in the legal aid/poverty law movement as a whole. As such it is recognised by practitioners. Further, it is probable that it affects those providing legal services to mental health patients, especially given the close relationship between the two groups.

This situation is conceptualised as a conflict between the needs of the individual client and the needs of the client group as a whole. As I have argued elsewhere (Bothmann & Gordon,1979), a conflict may arise between the interests of a particular client and the desire to run a case for the group of clients. A settlement in an individual case may be of great benefit to a single client but not assist the group as a whole by establishing, for example, a useful precedent. On the other hand, an action, the outcome of which might be useful for the group as a whole, may require a self-less client prepared to defer gratification and risk losing a benefit which might otherwise arise through a pre-hearing settlement. As such, it may involve the pursuit of an issue in the 'best interests' of mental health law as a whole rather than the 'best interests' of the individual patient/client.

Where the latter 'voluntarily consents' and it is an 'informed consent', no difficulty arises. Where it is a manipulated consent, voluntariness must be questioned just as it is in the health context. In the absence of research dealing with the problem its precise dimensions are unknown. However, it is conceivable that, given the complex nature of many issues and the conflictual character of law and psychiatry at the moment, a temptation is created for the practitioner. He or she may confront an unenviable dilemma when practising mental health law; viz, whether to consider the 'best interests' of the individual, the 'best interests' of the group, or the 'best interests' of mental health law. Fortunately the perceptions of need advanced by patients and patients' organisations suggest that the 'best interests' of all three 'groups' may be the same.

However this general situation tends to raise an ethical dilemma given that a lawyer has a professional duty to do his or her best for a client. Such a duty may involve advising clients on the 'best' course of action to take in order to ensure the client's 'best interests' are served. At the same time, however, the lawyer has wider duties. As Friedman points out (1975), a practitioner must be a zealous advocate for a client but at the same time be conscious of the 'public interest'. Whether or not a 'public' could be perceived to be a 'community' of patients/clients is largely moot. Further, the lawyer is bound to discharge a duty to the court and to the profession as a whole (Canadian Bar Association,1973,1974). As such he or she may be caught in an ethical dilemma; a situation which appears to be accentuated in the mental health context (Chernoff &

Schaffer,1971).

As many writers have pointed out (Chernoff & Schaffer,1971; Stone, 1975; Gostin & Rassaby, 1980; Brakel,1977; Ennis & Siegel,1973; Kopolow & Bloom,1977; Wald & Friedman,1978; Woody,1979; James, 1978; Gupta,1971; Weihoffen,1969; Polier,1968; Brakel & Rock,1971; Kindred,et al,1976; Mental Disability Law Reporter,1977a) the 'proper role' for the mental health lawyer is not easy to determine. The various delivery styles or roles appear to fall along a continuum between a 'strict instructions' approach associated with partisan advocacy,[27] and a more 'patient welfare' approach associated with mediation in, or non-litigous resolution of, disputes or conflicts (Gordon,1981; Woody,1977). Although the latter case is often described as a 'best interests' role (James,1978; Woody,1979; Gostin & Rassaby,1980) this is, I would argue, quite misleading. Lawyers adopting the delivery styles at both ends of, and along, the continuum assume they are operating in the 'best interests' of the patient/client.

The 'strict instructions' approach has been most adequately described by Gostin & Rassaby(1980):

> "...(a) strict instructions approach assumes that the patient is competent to aid the representative in the conduct of the case and to express a preferred outcome... If the patient is capable of expressing a view as to the outcome he desires and can provide minimal assistance to the representative, this should suffice for the purpose of carrying out instructions." (op cit:5)

This is the approach favoured by what appears to be a major proportion of mental health lawyers (Gostin & Rassaby,1980; Green,1979; James, 1978; Brakel & Rock,1971; Brakel,1977; Ennis & Siegel,1973), the courts, professional bodies and legislatures, especially in the United States (Powell,1978; James,1978; Brakel & Rock,1971). It is seen as the 'safest' approach to take for the lawyer is then able to operate within a familiar, ethically sound, traditional, lawyer-client relationship. It effectively acknowledges that 'competency' is not a condition with easily discernible parameters and is thus consistent with the reformative emphasis of the patients' rights movement. As such it also avoids the problems posed by the 'best interests' judgement.

On the other hand, advocates adopting the 'patient welfare' approach take a more conciliatory stance (Kopolow & Bloom,1977; Bolton,<u>et al</u>,1975; Weihoffen,1969). Again, as Gostin & Rassaby argue, in such a delivery style,

> "...(t)he traditional brief of the representative is considered...to be inappropriate in the context of mental health (issues). This view derives from the premise that a patient is unable to make realistic judgements...(A) successful outcome is a decision which best promotes the health and safety of the patient...(R)epresentatives pursue their perception of the patients' best interests rather than acting on strict instructions."(1980:5)

As James suggests,(1978) this means that lawyers construct an independent opinion and act irrespective of the client's wishes; an approach which plunges them firmly into the quagmire created by the questionable nature of any 'best interests' judgement. In addition, it also raises ethical dilemmas for, as Gostin & Rassaby point out,

> "...(t)he source of the representative's authority derives from the client. It must therefore be the client's assessment of a preferred outcome which takes precedence over any private view which the representative may hold."(1980:4)

The strict instructions approach, however, may be no safer for the patient/client given that it seems to employ its own battery of myths in relation to the power of clients in any lawyer-client relationship. As Rosenthal has pointed out (1970), in any relationship involving lawyers and clients one is never really certain who is actually 'in charge' and who is giving instructions to whom. This is the case particularly when the client is from disadvantaged and vulnerable social groups (Bothmann & Gordon,1979). The flow of 'strict instructions' from a client is often negligible. As a result lawyers tend to impose their own, occupationally determined values on a set of circumstances and re-interpret the situation for a client (op cit). Such manipulation may involve a re-definition of a client's problem into a conceptual framework familiar to the lawyer and perceived by him or her as an issue with a clear legal solution (see, e.g. Dickey & Remington,1976). This is particularly the case where both the problem and the solution involve complex issues that may be incomprehensible to a client unfamiliar with the peculiarities and language of law. In many ways this is, perhaps, an unavoidable situation given the lawyer's 'recipe' knowledge in respect of the formal and informal functioning of the legal system in any particular jurisdiction and the client's corresponding lack of skills and knowledge. Indeed, a lawyer may have a duty to do this in order to secure clarity in a case and thereby ensure that the best possible result is obtained for a client. However, it may involve, for the client, a considerable re-adjustment of his or her perception of legal need and the most appropriate way of dealing with a particular problem. Even though, as I have suggested, lawyers in such situations <u>may</u> be acting in the 'best interests' of clients they, clearly, cannot be said to be simply taking instructions.

Fuel is added to this fire by Stone who argues that, "having laboured hard to halt the reign of coercive and warehouse psychiatry...(the mental health bar)...now faces the equally disheartening prospect of the benevolent abandonment (of patients)" (1975:247-248). In this context it has been argued that aggressive partisan advocacy has not been in the 'best interests' of patients either individually or as a group. Even though advocates may have followed the instructions of their clients (whether individuals or organisations) and may have been successful with litigation on their behalf, the results have been either pyrrhic victories (the 'over-reach' of lawyers) or paper victories (the 'under-reach' of lawyers) (Steadman,1979a;

Wald & Friedman,1978; Bradley & Clarke,1976; Stone,1975; Kopolow & Bloom,1977; Barton & Sanborn,1978).

The issue of 'over-reach' has, of course, been discussed in the context of psychiatric-centred perceptions of patients' needs. It involves the allegation that the domination by those asserting civil rights needs has occurred at the expense of patients' health needs, especially where 'lodgement and care' is seen as the major objective. On the other hand, the issue of the 'under-reach' of lawyers addresses the ineffectiveness of legal actions. Although victories may be obtained in courts, the harsh reality is that much more has to be done before they are put into effect (Bradley & Clarke,1976). Rulings are not enforced, mental health authorities employ delaying tactics and often simply claim that no money is available to carry out the required reforms (Wald & Friedman,1978; Bradley & Clarke,1976; Kopolow & Bloom,1977). Although legal advocates can and do, continue to press for implementation of the 'paper' victories, their effectiveness seems to be limited. At two levels, then, it is claimed that aggressive advocacy is not necessarily in the 'best interests' of patients. The question largely left begging is "just what is the proper role for the lawyer involved in the delivery of legal services for mental health patients?"

The foregoing discussion should indicate that a complex situation exists in relation to the needs of mental health patients. On the one hand, there is an apparent conflict between the perceptions of need held by psychiatrists, lawyers and patients particularly in the context of health and civil rights needs. The two professional groups may be proceeding with an excessive reliance on the problematic concept of 'best interests' when defining need, assuming that their client/patient group is not competent to judge. It may be that whereas doctors perceive illness as a 'cause' of incompetence, lawyers perceive the complexity of the issues involved, as the main source of incompetency. That is, people from disadvantaged groups are unable to appreciate the significance of certain legal issues that may affect them. In addition, both groups may be engaged in internecine warfare the essence of which may be related to a larger professional rivalry only peripherally associated with conflicting perceptions of the needs of mental health patients. This may be proceeding without a recognition that a 'common foe' exists in the form of governments and their fiscal policies.

On the other hand, a noticeable element of agreement also exists. In many respects, patients' perceptions of health needs may correspond with those held by psychiatrists. Similarly, lawyers' perceptions of legal need may also complement the perceptions of health needs held by psychiatrists; indeed the latter may be encouraging the former. Further, whilst some aspects of lawyer-centred perceptions of need may not correspond with those held by individual patients, the origins of such perceptions may lie with patients' organisations who instruct the lawyer. Other aspects of lawyers' perceptions have a clear and direct bearing on needs as articulated by patients. Indeed, in the poverty law context answering the 'conventional' legal needs of patients may be beneficial not only in respect of the specific legal problem but also in relation to the health needs of patients.

It can thus be seen that those providing legal services for mental health patients confront a difficult and complex situation, not least of which involves the debate concerning the 'proper role' or delivery style of lawyers. As I have argued, the perceived conflict between health needs and legal needs is the core problem, the progress of which may be strongly influential in the development of legal services for patients. In Commonwealth jursdictions, where the evolution of mental health law is so tightly woven with the legal aid movement, the central conflict is further intensified by the content of legislation that directly affects mental health patients. As I have suggested, the actual practice of law for patients is closely bound to such legislation for it effectively prescribes the parameters within which legal workers must operate. This is particularly so as, unlike the United States, no substantial facility exists for the aggressive pursuit of patients' rights.

Such legislation tends to reflect attempts that have been made to accommodate the competing perceptions of need. As

Slovenko has noted(1977),

> "Legislators...balance competing interests and fears. They are laymen, relying on others for information (and) have responded to the most strongly phrased statements and fears..."(*op cit*:817)

In some places, this has resulted in substantial reform whereas, in other places, reform has been either avoided or limited to a process of making minor adjustments. Where a compromise has been attempted, however, the process appears to have created more confusion and conflict. As I will argue, in general, mental health legislation appears to favour psychiatric-centred perceptions of need, over other perceptions, but at the same time it has given passing acknowledgement to lawyer-centred perceptions of need. This possibility will be further examined through an assessment of the practical application of certain aspects of the relevant legislation. Patients' needs may appear to be answered but, in actuality, they may be ignored or otherwise overwhelmed. As a consequence, the operations of legal services may be restricted. In the next chapter, this issue will be explored in the context of one aspect of patients' needs as perceived by lawyers and, to some extent, patients; notably the provision of review procedures for those patients involuntarily committed in the *civil* context.

NOTES

1: See, also, generally, <u>Law and Society Review</u> Vol.11:2, 1977.

2: The difficulties involved in the growth of poverty law, discussed in the previous chapter, adequately demonstrate this problem.

3: For example, in the context of social welfare law; Social Security Appeals Tribunals. In the context of mental health law; Mental Health Review Tribunals.

4: This problematic issue has been subjected to considerable investigation, particularly in the mental health context. Because of its extensive character it can only be touched on briefly in this thesis. For a further debate see, Stone,1979b; Gostin,1979a; Grosman & Summers,1980; Mason,<u>et al</u>,1978; Somerville, 1979; Owens, 1977; Roth,1979; Singer,1977.

5: See, in particular, the recently released, <u>Diagnostic and Statistics Manual, Edition III</u>. This document, used by mental health professionals in the United States, has been compiled with the assistance of empirical research aimed at improving the reliability and validity of diagnoses.

6: 403 A2d 744 (DC Crt App, 1979).

7: See, for example, Vrooman, 1980; Talbott, 1978, 1980; Stickney, 1974; Schwartz, 1974; Steadman, 1979a; Schmolling, 1975; Reinert, 1979; Morris, 1970; Meisel, 1975; McGough & Carmichael, 1977; Katz, 1970; Hansen, 1975; Greenblatt, 1974; Golann & Fremouw, 1976; Barton & Sanborn, 1978; Bachrach, 1980; Armstrong, 1978; Appelbaum & Guthiel, 1979; Sehdev, 1976.

8: Similarly, different groups of mental health professionals may hold competing views of health needs. For example, the psychiatrists' perspective may not be held by clinical psychologists who may have a different conception of mental illness. Further, the views held by the American Orthopsychiatric Association (an inter-disciplinary organisation) seem to differ from those held by the American Psychiatric Association. It is thus apparent that a complex web of perceptions of health needs exists. A full exposition is beyond the scope of this thesis.

9: See, also, 'Patients Left Out in the Cold', <u>New York Times</u>, Dec 20th 1980. 'Emptying the Madhouse', Life, May,1981.

10: See, also, my discussion of Wyatt v Stickney in Chapter 2.

11: A study conducted in relation to determining whether or not patients diagnosed as schizophrenic were able to give informed consent in relation to drug treatment programmes.

12: These two studies, conducted in the United States, appear to be the only systematic research attempted so far in relation to determining legal need from the patients' perspective. One study (Brakel, 1978) was conducted by lawyers; the other was conducted by psychiatrists (Epstein & Lowinger,1975).

In the Epstein & Lowinger study, 50 patients (25 men, 25 women) at a state hospital were interviewed. Great care was taken to ensure that patients understood the issues canvassed and that their responses were considered and meaningful. Of the 50 patients only two were unable to respond in a meaningful way to all the questions whilst a further 13 had difficulty in relation to a specific question asked. In the latter case the researchers did not make clear whether the difficulty was due to a simple comprehension problem or to the effects of the patients' particular conditions.

In Brakel's study, 43 patients in two Illinois mental health institutions were interviewed and their hospital records examined. No difficulties were encountered in communicating with patients or in obtaining meaningful responses from them. However Brakel's method of selecting respondents (those using the institution library) doubtless biased the outcome.

13: In this study of clients attending a community law centre, it was found that 42% of the group (n=55) had pre-defined their problem as having a specifically legal solution whilst 29% felt that, in someway, a lawyer could help them. In addition, 38% had worked out, beforehand, what they wanted a lawyer to do for them and 45% had a vague idea of the type of action required.

14: The committee to consist of former psychiatric patients, citizens and a civil rights lawyer.

15: See also my general examination of mental patients' legal services in Chapter 3. In particular, see the limited data available in relation to those legal services that have developed in Commonwealth jurisdictions.

16: They reported that, "involuntary patients showed a greater tendency than did voluntary patients to request legal aid in the past and future and were most likely to want legal aid to help them get out of hospital."(1975:90) It is interesting to note that Brakel found this general sentiment expressed by some patients who were being held in a mental health institution following a criminal commitment. In one case cited a patient, charged with murder, had been committed as 'unfit to stand trial'. His status had been changed by the criminal court to that of being 'in need of mental treatment', although the authority for doing this was dubious. "There had been no trial on the charge and no finding of not guilty by reason of insanity to precede the need-of-treatment order." All the patient wanted was "...to be "out of this nuthouse," as he put it, and to stand trial on the murder charge."(Brakel,1978:582)

17: For example, a patient may be suddenly taken ill and be placed in hospital leaving many issues such as debts, housing and employment matters, unattended to in the community.

18: For example, a patient may be sued for divorce or lose welfare benefits. Creditors may attempt to sue him or her for debt and attempts may be made to proceed against the patient in tort for incidents prior to incarceration.

19: Any number of matters may require resolution before discharge. A patient may wish to settle debts, obtain accommodation, resolve a family-related legal problem or seek welfare entitlements (see, e.g. Dickey & Remington,1976).

20: As Rappaport and others (e.g. Farmer,1967; Weihoffen, 1969; Errion & Moen,1976) have argued, many patients may have critical social problems which can be seen to be the primary source of their demise; concomitant emotional disturbance becoming a secondary issue in the pursuit of the patient's recovery. Such critical social problems may have a legal solution.

21: See also: *Bolton v Harris* 395 F2d 642 (1968); *Humphrey v Cady* 405 US 504 (1972); *Specht v Patterson* 368 US 605 (1967); *Shelton v Tucker* 364 US 479 (1960); *Parham v J.R.* 99 S Ct 2493 (1979); *Sites v McKenzie* 423 FSupp 1190 (1976); *Re Rogers* 566 P2d 997 (1977); *Re Klepper* 49 Ohio St 2d 211 (1977); *Fasulo v Arafeh* 46 USLW 2168 (1977); *Lake v Cameron* 264 F2d 657 (1966); *Jackson v Indiana* 406 US 715 (1972); *Memmel v Mundy* 75 Wis 2d 276 (1977); *Re Gault* 387 US 1 (1967); *Re Fisher* 39 Ohio St 2d 7 (1974); *Williams v Overholser* 259 F2d 175 (1958); *Lynch v Overholser* 369 US 705 (1962); *Heryford v Parker* 396 F2 393 (1968); *Rogers v Stanley* 372 US 335 (1963); *Lessard v Schmidt* 349 FSupp 1078 (1972); *Lynch v Baxley* 386 FSupp 378 (1974); *Bell v Wayne County General Hospital* 384 FSupp 1085 (1974); *Re Popp* 33 Ohio App 2d 22 (1972); *Re Dawili* 9 CHR 59 (1975); *Addington v Texas* 99 S Ct 1804 (1979); *U.S. v DeCoster* 487 F 2d 1197 (1973); *Re Dearing* [1976] WWD 21; *Ex parte John Doe* (1974) 17 CCC (2d) 49.

22: See also: *Wyatt v Stickney* 344 F Supp 373 (1972) (continuing); *Rouse v Cameron* 125 US App 336 (1966); *Doe v Klein* 1 MDLR 475 (1977); *Welsch v Likins* 373 F Supp 487 (1974); *Davis v Watkins* 384 F Supp 1196 (1974) (continuing); *Donaldson v O'Connor* 493 F (2d) 507 (1974).

23: See also: *Winter v Miller* 446 F 2d 65 (1971); *Rennie v Klein* 462 F Supp 1131 (1979); *Rogers v Okin* CA No 75.1610T (Mass FDC 1979); *Kaimowitz v Michigan Dept of Mental Health* 42 USLW 2063 (1973); *Scott v Plante* 532 F 2d 939 (1976).

24: See also: *Dixon v Weinberger* 405 F Supp 974 (1975); N*.Y.S..R.C. and Parisi v Carey* 393 F Supp 715 (1975); *Baxstrom v Herold* 383 US 107 (1966); *Caswell v Califano* 488 CVW 4 (1977); *Nelson v Hudspeth* GC 74.1005 (ND Miss 1977); *Lake v Cameron* 264 F 2d 657 (1966); *Brewster v Dukalis* CA 76.4223 (FD Mass 1977).

25 See, also: *Jobson v Henne* 355 F2d 129 (1966); *McKeev Moritz* 11 CHR 951 (1978); *Souder v Brennan* 367 F Supp 808 (1973); *Downs v Dept of Public Welfare* 368 F Supp 454 (1973); *National League of Cities v Usery* 426 US 833 (1976). Although this last case overthrew the right to compensation as established by *Souder v Brennan* it had little impact on paid worker programmes already initiated by mental health authorities (Armstrong,1977).

26: For example, cases have been pursued in relation to the conduct of regimes in hospitals (e.g. the censorship of mail and curtailment of privileges for alleged misconduct)(Brown v Schubert 389 F Supp 281 (1975)); the confidentiality of patients' records (Doe v Beal CA 76.1396 (Ed Pa 1977)); the enforced payment of hospital expenses following involuntary commitment (McAuliffe v Carlson 377 F Supp 896 (1974)); and the seizure of the assets of patients before a proper test of their competency has been undertaken (Vecchoine v Wohlgemuth 377 F Supp 1361 (1974)).

27: Whilst it is not necessarily to be correlated with aggressive partisan advocacy (in theory, at least, it can involve adopting a conciliatory rather than adversarial approach to an issue if that is what is requested by a patient) the 'strict instructions' approach is closely associated with the vigorous pursuit of patients' civil rights and other legal needs, in an adversarial context.

V. ACCOMMODATING PERCEPTIONS OF NEED: THE CASE OF REVIEW TRIBUNALS

Although the evolution of mental health law in the United States has influenced the conceptualisation of patients' rights in other jurisdictions (notably the Commonwealth), it is clear that the acceptance of such rights in these jurisdictions has been cautious. This is particularly apparent in relation to the establishment of procedures by which patients are involuntarily committed and by which their cases are periodically reviewed.

In the United States, the right to 'due process' before the removal of liberty has been successfully employed in the mental health context, although the most appropriate mechanism through which to provide patients with a hearing has been subject to considerable debate (Andalman & Chambers, 1974; Anand,1979; Barton & Sanborn,1978; Cohen,1966; Crane, et al,1977; Ennis & Siegel,1973; Gupta,1971; Stone,1975; Gostin & Rassaby,1980; James,1978; Karlins & Knudsen,1976; Kopolow & Bloom,1977; Kumasaka & Gupta,1972; Columbia Law Review: Note, 1967; Hagel,1978; Wenger & Fletcher, 1969; Brunetti,1975; Litwack,1974; Roth,1980). Whilst some evidence has been produced to show that patients' rights are best protected by a hearing that employs an adversarial context modelled on procedures followed in conventional courts (Institute of Criminology,1978;

Green,1979; Gostin & Rassaby,1980; Greenland,1970; Wenger & Fletcher,1969) doubt has also been expressed that such hearings are little more than a sham.

In the Wisconsin case of Memmel v Mundy[1] for example, the court offered a scathing indictment of the shoddy legal representation given to persons at commitment hearings. A closed panel of court-appointed attorneys at hearings failed to cross-examine two out of three witnesses and asked an average of two questions in each case. Further the patient was often not in attendance at the hearing. As Wald & Friedman have noted (1978:151), "the onus of the debacle lies squarely with the lawyers and judges who operated this 'greased runway' to the county mental health centre." In Texas, Cohen found (1966) that, whilst the right to counsel had been given to patients, the conduct of the commitment hearings was questionable. At one centre he noted that 40 cases were heard in 75 minutes, the patient only appearing in two instances. A similar situation has been found in California, in the context of closely allied 'conservatorship' hearings. As Morris reports (1978), in such hearings;

> "...the competence of attorneys representing proposed conservatees is a critical issue...(L)awyers were inactive and ineffective in representing their clients' interests. The lawyers did not consider themselves advocates in an adversary process in which conservatorship was to be avoided. For example, of the sixty-three court hearings observed during the study period, thirty-six lasted three minutes or less, and only nine hearings lasted nine minutes or longer."(op cit:422)

Although such examples cannot be taken as sufficient reason for abandoning the idea of 'adversary hearings' (the problem may lie with personnel rather than the process itself), they have been used to support arguments in favour of commitment hearings that adopt a more conciliatory approach in determining whether or not a patient should be detained. To a certain extent, this issue has been considered by the courts for some time. In a 1957 case in the United States, (Dooling v Overholser),[2] the court indicated that patients had a right to counsel in civil commitment proceedings but that the hearing should not take place in an adversary setting. Similarly, in the later cases of Lake v Cameron[3] and Bolton v Harris[4] courts ruled that the commitment process was not an adversarial one, in the latter case expressing the view that the hospital should respond by assisting the court in acquiring all the relevant information on a patient's condition, treatment modalities and other relevant matters.

In the United States, this spirit of 'co-operation' rather than 'conflict' has tended, until fairly recently,[5] to be overwhelmed by the pursuit and establishment of commitment proceedings that adopt a more adversarial approach. However, in Commonwealth jurisdictions, the trend has been, very clearly, towards establishing pre and post commitment review hearings that adopt a non-adversarial stance (Gostin & Rassaby,1980; Institute of Criminology,1978; Shone,1976). As such, hearings have been conducted by tribunals set up under the tenets of administrative law. It is both in discussion of the role and operations of such hearings[6] and in analysis of legislation which established such bodies that it is possible to see a marked preference for psychiatric-centred perceptions of patients' needs. It is also possible to see a conflict between such perceptions and those held by lawyers, particularly where such practitioners are committed to the pursuit of patients' rights. I will now turn to an examination of this issue with a particular emphasis on the situation prevailing in Canada.

Although considerable attention has been paid to the process by which persons are initially 'certified' and admitted to hospitals (e.g. questioning the bases upon which diagnoses are made, the necessity for hospitalisation, and the length of time a person may be initially detained) other areas related to continued detention and case review have been of greater concern. The area in which the pursuit of patients' rights has been most obvious and, in the context of competing perceptions of need, most conflictual, lies with the issue of involuntary commitment and continued involuntary detention. That is, a focus has occurred on the process by which a patient is deprived of liberty against his or her will, in his or her 'best interests'.[7]

Many Commonwealth jurisdictions now have boards, tribunals, panels or other bodies set up to review, <u>inter alia</u>, the initial commitment and continuing detention of involuntary patients in both the civil and criminal contexts. In Canada, for example, nine provinces have review bodies established by mental health or related legislation[8] and all ten provinces have similar bodies established under Section 547 of the Criminal Code.[9] In England, Mental Health Review Tribunals were established by Schedule I of the Mental Health Act, 1959 (England/Wales) (see, also, my discussion of the Aarvold Board in Chapter 2), whilst in Australia, four states have established similar bodies.[10] An interesting exception is found in the state of New South Wales which has a facility for a Magistrate's pre/post commitment hearing similar to that found in Scotland and, to some extent, in New Zealand.[11] As such it would appear that considerable effort has been made to respond to lawyer-centred perceptions of need where this involves the provision of mechanisms by which a patients' deprivation of liberty is subjected to scrutiny. However, on closer examination this may not be entirely the case; a possibility that can be tested by an analysis, in the Canadian context, of the content of legislation establishing such mechanisms (in the case of civil commitment) and their application in practice.

As I have indicated, nine provinces have established review boards, panels or tribunals (hereinafter referred to as review tribunals) designed to deal with a range of issues affecting mental health patients.[12] The terms of reference governing the tribunals vary considerably. In some provinces, they are concerned only with providing hearings at specified periods during a patient's involuntary detention to review the patient's case. Such hearings are provided only if a patient or other party makes an application for review.[13] In other places, the review tribunal has a broader mandate and may review cases automatically. In Nova Scotia, for example, the review tribunal deals with a full range of issues affecting patients. It is concerned not only with commitment and continued detention but also declarations of capacity and competency, determining the appropriateness of psycho-surgery even where a patient or his/her guardian may consent, making recommendations in respect of treatment or care for particular patients and advising in relation to the type of treatment that is in the 'best interests' of a patient.[14] Unfortunately this example has not been followed in other provinces for, although the review tribunals in New Brunswick, Prince Edward Island, Quebec,[15] Alberta and Saskatchewan are all concerned with issues relating to declarations of incompetency as well as commitment and detention,[16] their mandate does not extend further. It is only in Ontario where review tribunals approximate the Nova Scotia 'model'. Commitment, continued detention[17] and competency matters are dealt with but, in addition, the review tribunal considers applications from physicians in relation to obtaining consent to treatment, where treatment is considered necessary but where consent is refused by the patient, or where the patient is declared to be incompetent.

Although review tribunals have been established in all provinces except Manitoba and a 'right' to apply for review is clearly specified in the relevant enabling legislation, limitations have been placed on the right that a patient may have when his or her application is placed before the tribunal. The right to apply for a hearing is not necessarily followed by a right to a hearing and, even where a hearing is to proceed, the conduct of the hearing may be affected by the absence of rights found in conventional court settings. In most provinces, the patient has a right to be present at the hearing unless considered detrimental (i.e. not in his or her 'best interests') in which case he or she may have a right to be represented.[18] Similarly, legislation in some provinces specifies a right to examine and cross-examine witnesses and make submissions to the tribunal.[19] Such rights are not, however, to be found in all provinces, nor is there any consistent relationship between the right to apply for review, the right to receive a hearing, the right to be present and/or be represented, and the right to test/present evidence before a tribunal. In addition, as I suggested earlier, there is no consistently established right to appeal the decision of a tribunal to another (judicial) body.

TABLE III

MENTAL HEALTH REVIEW TRIBUNALS AND PATIENTS' RIGHTS: CANADA 1980

	TYPE OF RIGHT		Attendance					Judicial Review		
Province	Review	Tribunal Hearing	Conditional	Uncond-itional	Represen-tation	Test Evidence	Make Submissions	In lieu of Tribunal	Appeal From Tribunal	Both
British Columbia	++	++		++	++		++			++
Alberta	++		++		++	++			++	
Saskatchewan	++		++		++	++			++	
Manitoba	++							++		
Ontario	++		++		++		++			
Quebec	++	++		++	++	++	++			
New Brunswick	++		++		++	++	++			
Prince Edward Island	++		++		++	++	++			
Nova Scotia	++	++	++		++		++	++		
Newfoundland	++	++	++			++	++			

Table III provides a breakdown of the relationship between these rights, across all ten provinces. It will be noted, firstly, that in all provinces patients have a legislatively prescribed right to 'request' or apply for a review of their case.[20] However, only four provinces (British Columbia, Quebec, Nova Scotia and Newfoundland) have reinforced this right with what would seem to be an equally important and logically consistent right to actually receive a tribunal hearing.[21] Instead, tribunals have been invested with a discretionary power typically portrayed by Section 32(1) of the New Brunswick, Mental Health Act (RSNB 1973 c.M-10):

> "Upon receipt by the chairman of a review board of an application in writing the review board shall conduct such inquiry as it considers necessary to reach a decision and may hold a hearing..."(my emphasis).

As such the patient has a right to have his or her case reviewed but not a right to a hearing, *per se*. This contrasts sharply with the situation in the four provinces mentioned above who have enshrined such a right. A typical example is provided in the case of Nova Scotia:

> "A review board shall conduct a hearing for the review of a patient's file upon the request in the prescribed form by any person..."(my emphasis)
> (Sec.58(2) Hospitals Act SNS 1977 c.45).

If a patient's application is favourably viewed by a review tribunal or otherwise passed on to the stage of a hearing limitations then appear to be placed on the patient's right to attend in person at the hearing. It will be noted from Table III that, with the exception of Quebec, a patient's right to appear is conditional. In general the relevant legislation specifies the right to attend but then qualifies that right. This process is typically portrayed by Sec. 40(2) of the Alberta <u>Mental Health Act</u> (RSA 1972 c.118):

> "The applicant and his representative have the <u>right</u> to be personally present during the presentation of any evidence to the review panel, but if in the opinion of the review panel there may be an adverse effect on the applicant's health by his presence, the applicant may be excluded."

Presumably this provision is included in the 'best interests' of the patient although the vagueness of the wording could lead to a suggestion that the principal interest, in fact, lies with the tribunal itself. Clearly the power to exclude a patient may be necessary in certain circumstances but in the absence of clearly defined circumstances such a power could be used to excess.

In such instances, however, care has generally been taken to ensure that when a patient is so excluded a representative takes his or her place. Indeed it is only in this situation that a right to representation exists. In Nova Scotia, for example, the relevant section provides as follows:

> "Where a hearing is held, the patient unless otherwise ordered by a review board and in any case his representative, shall have the right to attend and be heard."
> (Sec. 58(5) <u>Hospitals Act</u> SNS 1977 c.45).

As Table III indicates, this tends to be a typical provision in eight provinces where tribunals operate, the exception being

Newfoundland where the right is not clearly enunciated.[22] As such it could be argued that sufficient control is placed on arbitrary, exclusionary actions on the part of a tribunal as well as ensuring that, in his or her absence, a patient's perspective on decision-making will receive due consideration. However, as I shall indicate later in this chapter, this may only be a theoretical state of affairs.

Even where a patient is allowed a hearing and is either present and/or represented at the hearing, limitations may be placed on the procedure before the tribunal. It will be noted from Table III that in four provinces, patients and/or their representatives have an unconditional right to test the evidence presented to the tribunal, to present their own evidence and to make submissions to the tribunal. This is typically portrayed by Sec. 32(3) of the New Brunswick <u>Mental Health Act</u> (RSNB 1973 c.M-10):

> "Where a hearing is held the patient or his representative may call witnesses, cross examine witnesses, and make submissions."

As such, it seems that conventional legal rights are enshrined, the right to a full test of evidence and the presentation of alternative arguments being clearly established. Strangely, this situation is not repeated in all jurisdictions. In two provinces, a right to test evidence is established but without a corresponding right to present evidence or make submissions; the admission of such material is left to the discretion of the tribunal. This is illustrated by Secs.39(2) and 40(3) of the Alberta <u>Mental Health Act</u> (RSA 1972 c.118):

> "...the review panel shall carry out whatever investigation and hearing it considers necessary and <u>may</u> invite the applicant and any other person to testify or produce evidence at the hearing."
> (Sec.39(2))(my emphasis)
> "The applicant or person acting on his behalf has the <u>right</u> of cross examination."
> (Sec.40(3))(my emphasis)

Conversely, in three provinces, a right to make submissions or present evidence is established without a corresponding unconditional right to test evidence. As Section 29(3) of the Ontario <u>Mental Health Act</u> (SO 1978 c.50) typically indicates, the testing of evidence is, again, subject to the discretion of the tribunal:

> "Where a hearing is held, the patient or his representative may call witnesses and make submissions and, with the permission of the chairman, may cross-examine witnesses."

It is thus apparent that only in Quebec are patients' rights in respect of review tribunals consistently established such that the right to apply for review is followed by corresponding rights in relation to the conduct of a review hearing. A principal barrier appears by way of the absence of a right to a hearing but even in those provinces that have such a right there may be (with the exception of Quebec) no corresponding rights to test evidence (British Columbia and Nova Scotia) or be represented (Newfoundland). Conversely, some provinces that have established full procedural rights for patients (New Brunswick, Prince Edward Island) have not enshrined a right to a hearing. This general inconsistency across provinces seems rather curious and may reflect the type of approach to the conduct of hearings favoured and employed by authorities establishing the review tribunals.[23] It also tends to suggest that in many provinces an attempt has been made to reach a compromise between competing perceptions of patients' needs <u>vis-a-vis</u> case review procedures. However in doing so, legislators have created a confused and inconsistent, rather than an effective and standardised, situation.

Some provinces, perhaps sensitive to the absence of protections that may arise where rights are not properly and consistently established, appear to have taken a further step in seeking a compromise between legal and psychiatric perceptions of patients' needs. By offering patients the right to an alternative review mechanism by way of judicial review, they are in effect offering a choice of venues and procedures through which the issue of what is in the patient's 'best interests' may be pursued. On the one hand, a patient may choose the informality of a review tribunal or, on the other hand, may choose to have his or her case dealt with (initially or by way of appeal) in a strict adversarial context before a Judge of a Provincial Supreme Court (British Columbia), County Court (Manitoba, Nova Scotia) or Court of Queens Bench (Alberta, Saskatchewan). In addition, the judicial review facility provides an appeal process that has the benefit of speed and relative simplicity at the same time having, at least in one province (British Columbia), an impact similar to that found in relation to the prerogative writs.[24] It is therefore unfortunate that legislatively prescribed judicial review facilities exist in only five provinces (see Table III),[25] one of which has no other review procedure for patients. However, even in these jurisdictions some limitations are still apparent. In two of these provinces (Alberta and Saskatchewan) judicial review is only permitted on appeal from a decision of the review tribunal rather than as an alternative <u>initial</u> review process, whilst in Nova Scotia judicial review is only permitted as an alternative to a review tribunal rather than on appeal from a decision of a tribunal.[26]

Patients' rights in relation to commitment and continued detention decision-making are, therefore, in a confused and inconsistent state across Canada. The right to apply for review is not necessarily followed by a right to receive a hearing. The right of attendance is invariably conditioned by a discretionary power vested in the tribunal. Although a right to representation may exist where a patient is excluded from the hearing, the impact of a representative may be limited by the lack of rights in relation to testing evidence presented to the tribunal or in relation to presenting evidence/making submissions. Finally, the right to appeal a decision of a review tribunal to a higher authority is limited to three provinces and a right to seek initial case review in a strictly judicial context is only available, again, in three provinces. Thus whilst it could be argued that patients' rights in this specific area are being enshrined and protected by virtue of the establishment of review tribunals, a closer scrutiny of the relevant enabling legislation raises considerable doubt in relation to the actual effectiveness of such rights.[27]

Such doubt is increased when the actual operations of such review tribunals are taken into consideration. Clearly the enabling legislation associated with these bodies indicates a marked preference for a non-conflictual approach to handling commitment and continued detention matters. As Sharpe has noted (1980), mental health review tribunals are administrative rather than quasi-judicial tribunals and, within certain limitations, do not have to follow the rules of procedure associated with conventional court settings. For example, as the legislation tends to indicate, there is no compulsion to follow any of the familiar features of the adversary system or provide any of the traditional guarantees against arbitrary detention although, as Sharpe argues (<u>op cit</u>), it is becoming increasingly apparent that the courts are determined to provide at least one safeguard; the review of tribunal decisions via the prerogative writs.[28] This trend is of particular importance in those jursidictions that do not have a facility for judicial review or other 'appeal' procedures.

This preference for non-adversarial proceedings seems to reflect psychiatric-centred perceptions of need. On the one hand, psychiatrists seem to espouse a concern that patients will suffer if they are subjected to judicial-style proceedings. On the other hand, as many writers indicate, the concern may actually be for the comfort of the psychiatrists themselves, particularly as they do not appear to enjoy confronting challenges to their expert judgements (Brakel & Rock,1971; Bazelon,1974; Burris,1969; Gostin,1977; Institute of Criminology,1975; Kopolow & Bloom,1977; Stone,1975; Kumasaka & Gupta,1972; Polier,1968). As Haines (1978) and others have indicated (Institute of Criminology,1975; Standing Social Development Committee,1978; Stone,1975), in adversary style hearings psychiatrists may find the process of being subjected to cross-examinations by lawyers, time-consuming, demeaning, unnecessary and contrary to their principal goal of attending to the health needs of their patients. Psychiatrists, it is argued, have better things to do with their time than stand in court answering lawyers' questions (Institute of Criminology, 1975). As Haines argues (1978), psychiatrists should, however, come to understand the lawyer's duty in this regard and recognise the need for a careful testing of the reasons for depriving others of their liberty. As Bazelon has argued, (1974) challenging the expert - questioning the judgements of those with power - is the life-blood of the legal system. The 'guild' mentality of many psychiatrists may lead them to believe that they are somehow above such challenges but this really reinforces the need for a close scrutiny of the competency of their judgements and opinions. Psychiatrists, then, clearly reject the 'prosecutor' and 'defence' roles that are associated with an adversary setting. The absence, in Canadian legislation, of a consistent application of the characteristics of an adversary setting to current review tribunal hearings, tends to suggest that psychiatric opinions have been allocated a greater priority by legislators.

The composition of the tribunals provides some indication of the acceptance of this preference for a non-adversarial approach. In Canada, although the size of the membership of a tribunal may vary, in general at least one member will represent the medical profession, another the legal profession and a third, the general community.[29] There is thus no dominance on the part of any particular professional group (at least in theory) and no judicial official having any decision-making power independent of the other tribunal members. A second indicator can be found, as I have noted, in the legislation and accompanying rules governing the conduct of the hearings. In general, a broad discretion is given to the tribunals in relation to the 'investigation' of any given case such that, whilst they may hear testimony from different sources and may allow the cross examination of persons giving evidence, they are not compelled to follow any particular format.

Whilst it could be argued that it may be in the patients' 'best interests' to have his or her case reviewed by a body that seeks a solution through co-operative action rather than conflict, there are attendant risks - particularly where 'co-operative' action is replaced by professional dominance. Unfortunately, apart from general discussions of their role and function (e.g. Savage,1980) and illustrations of injustices that arise as a consequence of their work,[30] very little is known about the operations of both civil and Criminal Code review tribunals. The only traceable Canadian research on the topic has been undertaken by Shone (1976) and, to a limited degree, by Dockerill (1972).[31] Some further information can be gleaned from general accounts of the operations of review tribunals from the point of view of their members (see e.g. Haines,1978,1980; Gilmour,1976; Savoia,1976) and from those representing patients (Green,1979; Standing Social Development Committee,1978). In addition, given that, as Gostin points out (1979a) the England/Wales Mental Health Act,1959, has had a significant influence on mental health policy in the Commonwealth, the experiences of practitioners dealing with review tribunals in that jurisdiction are also generally useful (Gostin,1977,1979d; Greenland,1970; Bacon,1975; Gostin & Rassaby,1980).[32]

It is clear from such material that, in keeping with the discretions embodied in the relevant enabling legislation, considerable variation exists in relation to the procedures adopted by different review bodies. Some review tribunals adopt a 'legal conference' method when conducting their hearings (Haines, 1978,1980); a model that attempts "to graft the inquisitorial system on to adversarial procedures" (Savoia,1976:1). On the other hand, other review tribunals adopt a process of adjudication approaching the adversarial model whilst some prefer an informal conference model normally associated with purely administrative matters (op cit). However, no information is available to assist us in obtaining a precise breakdown of which provinces have review tribunals following which type of model in either the civil or Criminal Code contexts.

Where the legal conference method is utilised, it is clear that the objective is to avoid the 'polarisation' associated with the adversarial system, at the same time seeking to establish the 'truth' of a case with the full participation of the patient (Haines,1978). A principal objective is to balance the need to protect a patient's rights with his or her health needs; more specifically his or her health needs in relation to the particular, current therapy being undertaken by the patient (Haines,1978,1980).[33] Considerable concern is expressed that patients will somehow perceive the process as the equivalent of a criminal trial with its associated notions of 'guilt' and 'innocence', and, as a consequence, come to see themselves as 'defendants' rather than participants in an enquiry designed to determine what is in their 'best interests'. As a consequence, it is argued, the patient's self-image may be adversely affected with an attendant disruption to therapies designed to overcome such negative feelings (Shone,1976). Whilst a laudable intention, it must be noted that this assumption appears to be based largely on psychiatric-centred perceptions of patients' needs independent of any attempt to actually determine patients' views on the matter; an approach consistent with the idea that patients are unable to determine what is in their 'best interests'.

This approach is even more apparent where the 'informal conference' model is adopted by review tribunals. Although no reliable data on the operation of such bodies is available some limited enquiries by this writer in one province where review tribunals dealing with civil cases have adopted this particular approach (British Columbia), tend to support the proposition[34] (see, also, Dockerill,1972). Although a lawyer may act as a representative for a patient his or her role is uncharacteristic of that traditionally ascribed to a lawyer acting for a client. As a member of the review tribunal as well as the patients' appointee, the lawyer is essentially serving as both judge and advocate, taking part in the discussions pertinent to the 'disposition' as well as advancing the patients' perspective. It is this duality that many practitioners see as untenable (Green,1979; Gostin & Rassaby,1980) and which, perhaps more importantly, patients appear to find confusing.[35] Although a lawyer acting for a patient may hold a pre-hearing conference with his 'client' during which they might discuss the possibility of community treatment alternatives, the sources of support that may exist in the community and other matters relevant to the compilation of an argument in favour of discharge from the institution, the only opportunity for the advancement of such matters occurs in the context of an informal discussion between the members of the tribunal. Following the discussion, the patient may be called before the tribunal and given an opportunity to address the members. In turn, he or she may be subjected to questioning perhaps by his or her appointee who will attempt to raise matters helpful to the patient. The tribunal then considers all the points of view and attempts to arrive at a conclusion that is in the 'best interests' of the patient.

It will be clear from this description that the conventional procedures, and therefore protections, found in relation to court proceedings are not followed. Although the patient is offered an opportunity, via his or her appointee, to indicate what he or she feels is in his or her 'best interests', the individual who will advance that perspective is also a person who will deliberate on the matter and who, whilst receiving 'instructions', is also engaging in a process of pre-hearing determination. The lawyer is not only absorbing the patients' perception of need but also drawing conclusions in relation to what is in the client's 'best interests'.[36] It has been noted that, if this review panel was not supplemented by a right of appeal or direct application for initial review to a judicial facility (in the civil commitment context), serious doubts could be advanced in relation to the justice of review proceedings in the province (Green,1979).

Although it could be argued that such procedures at least allow the advancement of a patient's perception of need, the extent to which that perception is allocated legitimacy is questionable. In the course of a recent review of the provincial Mental Health Act, the Ontario Standing Social Development Committee (1978) heard evidence from a legal worker who had acted as a patients' representative in proceedings approximating the 'legal conference' model.[37] Her testimony suggested the presence of an inbalanced input at review hearings. Whilst the composition of the review tribunals included a clergyman, a legal practitioner and a layperson, the psychiatrist member of the tribunal was seen to completely dominate the proceedings. In one case quoted, despite circumstances surrounding the hearing that did not assist the patient, the particular appellant appeared to conduct herself in an intelligent and rationale fashion. In the patient's view both her prescribed chemo-therapy and her involuntary institutionalisation were unnecessary and she sought treatment, on an out-patient basis, that involved alternative forms of therapy. As the latter included association with an organisation that was deemed to be unacceptable to psychiatrists simply because it challenged their monopoly on the provision and determination of 'suitable' treatments, it appeared that considerable bias entered the process of decision-making. As the legal worker pointed out:

> "After (the patient) was returned to the ward, the psychiatrist (who had dominated the hearing) told her lawyer and myself that if we knew what was good for our client we would make sure that she did not go to such places as the Hassle-Free Clinic..."
> (Standing Social Development Committee,1978: S1720-2)

Such vignettes do not, of course, necessarily indicate that bias is widespread. However, it is possible to argue that in many instances a patient's perspective is not accepted because of deference to the psychiatrist's expert knowledge. Tribunal members may be, theoretically, in a position where they can intervene on a patient's behalf but, perhaps because of a lack of confidence in the validity of their judgement, choose not to pursue or support the patient/client's perspective of need. As review hearings have been described as 'kangaroo' or 'pyjama' courts by both patients and their representatives (Standing Social Development Committee,1978; Institute of Criminology, 1978) in different jurisdictions one can only assume that considerable dissatisfaction exists in relation to the conduct of review hearings.

Even where a patient may be represented by a 'partisan' lawyer, at hearings more closely approximating conventional adversarial settings, their perspective may not receive an adequate airing. As Shone's study (1976) indicates, the conduct of Alberta review tribunal hearings (particularly in relation to civil commitments) suggests that tribunals may be failing in their attempt to balance the competing interests or perceptions of need, because of their reluctance to adopt even the elementary aspects of a court setting. Although she acknowledged the danger of 'over-judicialisation' and the possible need to avoid generating a sense of 'wrongdoing' in the patient, there was evidence to suggest that in failing to acknowledge its essentially judicial, rather than administrative, function the tribunals were accepting and reinforcing a bias towards a medical model of adjudication that over-rode the basic tenets of natural justice. Thus, whilst lawyers may be present at review tribunal hearings to represent patients, they were unable to effectively advance the patients' perception of need and had reason to doubt the impartiality of the tribunal in situations where they were actually able to present 'evidence' or cross examine 'witnesses'.[38]

Indeed, the seriousness with which panels view the patient's lawyer's role in the proceedings is adequately demonstrated by one incident observed by Shone where the tribunal, having excluded a patient from the hearing in his 'best interests', appointed a lawyer from the Public Trustee's office to act for the patient. Whilst this may seem to be a clear demonstration of the panel's enthusiasm to ensure that the patient's perspective was adequately advanced, it must be realised that the lawyer in question was waiting to represent the Public Trustee's office in a competency matter and had neither knowledge of the client's circumstances nor any experience in mental health matters beyond that pertaining to the management of estates. He was, in effect, thrown a 'dock brief' that he was reluctant to catch. As Shone put it:

> "No one was more startled than the lawyer himself when the chairman named him to act during the applicant's exclusion...He sat through the medical evidence in self-conscious silence. Not once did he confer with the applicant or endeavour to speak on his behalf. The appointment smacked of pretense."(1976:179)

Such pretense may contain an element of displeasure where a truly partisan advocate does appear for a patient. As Shone noted (<u>op cit</u>), the friction between mental health practitioners and lawyers affects review tribunal attitudes towards lawyers who discharge their duty to a client in a traditional (indeed ethical) fashion. It is a friction that may in fact harm a patient who is attempting to have his or her perception of need advanced by a representative, where, irrespective of legislative intent, a tribunal personally favours the 'medical model' of decision-making. In one incident encountered by Shone (<u>op cit</u>), a member of a review tribunal, on hearing that a patient was represented, was heard to remark, "oh no, there goes the morning," a clear reference to the time-consuming and perceived wastefulness of having lawyers appear for patients.

The extent to which this negative impression affects review tribunal decision-making is moot. However, it is possible to argue that where review tribunals favour a non-conflictual approach to the conduct of hearings and demonstrate a willingness to accept a domination by physicians who are members of panels, an objection to a lawyer who attempts to advance his client's perspective in an adversarial context may flow over into the subsequent deliberations of the tribunal. The effect may be such that lawyers who (perhaps in keeping with the spirit of the relevant legislation) adopt a partisan advocate approach may find that they are not acting in the 'best interests' of their client. In such circumstances the client becomes the victim of a conflict between two competing perceptions of the client's needs disguised as an exercise in determining what is in his or her 'best interests'.

The foregoing analysis of the provision of Canadian legislation pertaining to review tribunals and the brief discussions of the problems or review tribunals in practice suggest, it is argued, three main things:

1. It is apparent that psychiatric-centred perceptions of

patients' needs(and perhaps their own needs) have strongly influenced the content of enabling legislation. Where patients' rights have been established they are splintered and inconsistent to the point where they may be largely ineffective. As such only 'lip-service' appears to have been paid to lawyer-centred perceptions of need and, as a consequence, the conventional protections afforded to persons who have had or are about to have, their liberty curtailed, are absent.

2. In granting wide discretion and powers to review tribunals, vis-a-vis the conduct of their hearings, an attempt appears to have been made to encourage an informal approach to decision-making. Although the composition of tribunals is largely mixed, it appears that some degree of psychiatric domination may occur. As a consequence the informal approach may be a facade concealing a charade. The psychiatrist member of a tribunal may be more inclined to simply accept the recommendations made by a colleague treating the appellant and, because of his or her 'expert' status, may have the power to effectively encourage other members of the tribunal to automatically follow suit. In the absence of research, the precise extent to which this may occur is unknown.

3. Even where legislation provides for representation and an active role on the part of a lawyer representing a patient,

the application of this role may actually be counter-productive to the patient's interests. As the psychiatric-centred perception of patients' needs seems to dominate the activities of tribunals and as such perceptions include a rejection of a process of case review in an adversarial context, a lawyer who attempts to apply his client's rights may confront an hostile rather than impartial, tribunal.

In attempting to strike a compromise between competing perceptions of need, legislators may have created both confusion and further conflict. Clearly the overall situation does not assist those providing legal services to mental health patients; a somewhat paradoxical state of affairs given that, as indicated in Chapter 3, the development of review proceedings can be seen as a source of encouragement in the evolution of such services. In theory and in practice, the task confronting legal workers is complex for whilst they have been given encouragement with one hand their work has been restrained with the other. Such workers therefore face a two-fold task: i) the effective representation of patients within existing structures (both those created by legislation and those created by the actual conduct of tribunals); and ii) a continued fight for the establishment of effective and consistent rights and for the just and equitable conduct of hearings by tribunals.

NOTES

1: 75 Wis 2d 276 (1977). See also Wallace v Kerm 13 CLR 2243 (1973).

2: 100 US App DC 247 (1957).

3: 264 F2d 657 (1966).

4: 395 F2d 642 (1968).

5: See, in general, my discussion in Chapter 2.

6: See my discussion in Chapter 2.

7: It should be noted that this is not the sole reason for depriving a patient of his or her liberty. It may also be deemed necessary in the 'best interests' of the community at large if it is believed that the patient is 'dangerous'. However, as I noted in Chapter 4, I am principally concerned with perceptions of patients' needs rather than the needs of the community. This latter issue will, therefore, be by-passed.

8: The relevant legislation will be itemised and discussed in depth in this Chapter.

9: In some provinces these bodies, known as Lieutenant Governor's Advisory Review Boards, are distinct from the mental health review boards/panels set up under mental health and related legislation (British Columbia, Saskatchewan, Manitoba, Alberta, Quebec, Nova Scotia, Newfoundland). In other provinces the mental health review boards/panels have a combined role, dealing with both those involuntarily committed in a civil context and those involuntarily committed in a criminal context (Ontario, Prince Edward Island, New Brunswick).

10: South Australia (Sec.29, Mental Health Act 1976-1977).
West Australia (Sec.11, Mental Health Act 1962 (under review)).
Queensland (Sec.14, Mental Health Act1974).
Tasmania (Sec.22, Mental Health Act1963).

11: New South Wales (Sec.12, Mental Health Act1958).
Scotland, (Sec. 28, Mental Health (Scotland) Act 1960).
New Zealand (Sec.21, Mental Health Act 1969).
In these jursidictions, review procedures are made available by way of pre or post commitment hearings before Magistrates or

their equivalent. The reasons for the selection of the different procedures in the various Commonwealth jurisdictions (particularly between the years 1958 and 1963) and, where no review facilities are provided, the use of 'Official Visitors' as an alternative (e.g. in the state of Victoria, Australia), is worthy of closer investigation.

12: In five of these provinces, ~~the~~ 'protective' effect of such tribunals has been supplemented by enshrining a specific right of appeal or application for review, to a purely judicial body. This will be discussed more fully later in this chapter.

13: British Columbia: 30 days after commitment and then at any time providing a review has not occurred in the preceding 6 months (Sec.21, *Mental Health Act* RSBC 1979 c.256).
Newfoundland: Application may be made at any time but the application may be dismissed summarily if it is made within 6 months of a previous, unsuccessful appeal. (Sec.17, *Mental Health Act* SN 1971 c.80).

14 : The tribunal is *obliged* to review cases every 6 months for up to 2 years and then annually, or *within* 30 days of a request by a patient or other party unless a review has occurred within the previous 6 months (Sec.57, *Hospitals Act* SNS 1977 c.45)

15: Note that, in Quebec, the equivalent of a review tribunal is provided through the Mental Patients' Protection Division of the Social Affairs Commission.

16: New Brunswick: an involuntary patient or representative may apply for review 30 days after commitment and then on every renewal of a certificate (at first after 2 months, then a further 3 months, then 6 months and, finally, annually) (Sec.31, Mental Health Act RSNB 1973 c.M-10).
Prince Edward Island: as New Brunswick (Sec.26, Mental Health Act RSPEI 1974 c.M-9).
Quebec: a patient or any person may request review within 90 days of commitment. Whenever a person is involuntarily committed the relevant institution must, after 30 days, notify the review tribunal who may then make an enquiry even though a patient or other party has not made an application. Similar notification must also be sent on renewal of detention (every 6 months) (Secs. 48 & 48A, Mental Patients' Protection Act SQ 1972 c.44).
Saskatchewan: a patient or nearest relative may make an application for review on one occasion only following commitment and on the issue of each renewal certificate (every 3 months for 1 year and then annually) (Sec.24, Mental Health Act RSS 1963 345 (under review).
Alberta: a patient or representative may apply for review 30 days after commitment and then on every renewal of a certificate

(at first after a further 60 days and then every 6 months) (Sec.38 Mental Health Act RSA 1972 c.118).

17: A patient or any person may apply for review when a certificate of involuntary admission comes into force, on renewal of a certificate (after 30 days, then a further 60 days and, finally, every 3 months) or when a voluntary patient is re-classified as involuntary (Sec.28, Mental Health Act SO 1978 c.50).

18: This seems to be the case in all provinces except Newfoundland but is most clearly expressed in Quebec:

> "The (Social Affairs) Commission must, before rendering any decision, allow the parties to be heard. At the proof and hearing, each party is entitled to be assisted by an advocate and may examine the witnesses and state his arguments. The Commission shall ascertain, when it hears an application for review (from a mental health patient) that the person making the application is represented by an advocate."
> (Sec.35, Social Affairs Commission Act SQ 1974 c.39).

19: Quebec, Newfoundland, Prince Edward Island, New Brunswick.

20: The occasions upon which such applications can be made are laid out in notes 13, 14, 16, and 17 above.

21: It should be noted that, in Newfoundland, where a right to a hearing is established, this is conditioned by a discretionary power awarded to the tribunal. Under Sec.18, Mental Health Act (SN 1971 c.80) the tribunal may, with the approval of the Minister of Health, dismiss an appeal summarily if, i) considered to be vexatious, frivolous or not made in good faith; ii) the appellant does not have a personal interest in the subject matter; or iii) it is within six months of a previous appeal. Items i) and ii) are similar to the wording of Sec. 141 of the Mental Health Act (England/Wales),1959, the restrictive effect of which was discussed in Chapter 2.

22: See Sec.18(3) Mental Health Act SN 1971 c.80.

23: The different approaches that appear to be taken will be discussed later in this chapter.

24: Sec. 27 Mental Health Act RSBC 1979 c.256.
A person may apply to the Supreme Court for an order prohibiting the admission of a person to hospital (writ of prohibition), and an order that the patient be discharged irrespective of the review panel's deliberation (writ of *habeas corpus* with *certiorari* in aid).

25: A provision for judicial review (on appeal from a tribunal decision) has been included in the Ontario Mental Health Act (SO

1978 c.50: Sec 30F) but has not yet been proclaimed. A strictly limited right of review also exists in Newfoundland (Sec.19 Mental Health Act SN 1971 c.80), where a patient may appeal a decision of a review tribunal, to the Provincial Supreme Court, on a question of law only.

26: It should be noted, however, that in Nova Scotia the relevant section is so worded that it could be construed to provide for an appeal from a review tribunal. (See Sec. 39(1)Hospitals Act SNS 1977 c.45)

27: In addition, but closely connected to the issues examined in this area, considerable concern has been expressed that, in representing patients before tribunals, legal workers are at a disadvantage where they cannot gain access to relevant hospital records (see, e.g. Standing Social Development Committee,1978; Gostin & Rassaby,1980). Resistance to allowing representatives to gain access is justified on the basis that this would breach doctor/patient confidentiality and, where such records were viewed by a patient, could lead to disruptions in relation to therapy. In addition it may place a legal worker in an awkward position where he or she guaranteed not to expose the contents of a file to a patient/client when taking instructions/giving advice. Although this debate will continue for some time, some provinces have recognised that despite the 'ethical' dilemmas a patients' representative needs to be able to view at least part of a patient's record in order to properly represent a patient. Consequently a limited right has been established. See Sec.63, Hospitals Act SNS 1977 c.45; Sec.50.1 Mental Health Act RSA 1972 c.118. See also Sec.30d Mental Health Act SO 1978 c.269 (unproclaimed). See, also, the judgement in Re Abel,et al, and Advisory Review Board (1981) 56 CCC (2d) 153, discussed in Chapter 2. Where such provisions do not exist (i.e. in all provinces except Nova Scotia and Alberta) it could be argued that the already questionable effect of those rights that have been established in relation to review hearings is further reduced.

It is also necessary to consider the extent to which patients have been granted a right to be notified of their rights in respect of review hearings. It has been widely recognised in the context of legal aid generally that unless persons are advised of their rights and the exercise of such rights is proactively encouraged, clients will generally not pursue their entitlements for a number of reasons. In the mental health area, the often incapacitated state of the client may require more substantial mechanisms that ensure he or she is made aware of the right to have a case reviewed periodically. Without this, the establishment of a right to apply for a review hearing may be considered to be weakened.

In several provinces, the relevant legislation specifies that patients have a right to be notified of the right to apply for review (British Columbia, Alberta, Nova Scotia, Saskatchewan), whilst in Quebec a more substantial mechanism is established; viz, a provision for automatic case review regardless of the patient's application. (See also the Ontario <u>Mental</u> <u>Health</u> <u>Act</u> SO 1978 c.50: Sec.28 (yet to be proclaimed)).

28: See, also, my discussion in Chapter 2 of cases pertaining to the conduct of review tribunals.

29 : Presumably the 'reasonable man'. The following is a breakdown of the composition of tribunals, by province:
British Columbia: One 'lay' chairperson, one physician, one patients' appointee (provided by the Legal Services Society of B.C.).
Alberta: Two physicians, one solicitor, one public representative.
Saskatchewan: One physician, one lawyer, one 'other' person.
Nova Scotia: not specified in the legislation or attendant regulations.
Quebec: One advocate and three others including a psychiatrist.
Prince Edward Island: One County Court judge, one physician, and one other person (not a lawyer or physician).
New Brunswick: One judge of the Court of Queen's Bench, one

psychiatrist and one other person (not a lawyer or physician).
Newfoundland: One Barrister, one physician and one other(not a barrister or physician).
Ontario: One or two physicians, one or two lawyers, and one other person.
This pattern of membership is also found in other Commonwealth jursidictions.

30: See my general discussion in Chapter 2.

31: This research vacuum is due in part to the lack of concern for and interest in, this particular area but, in the main, is due to the reluctance of review tribunals to allow research access to their hearings. Such an intrusion is not considered to be in the 'best interests' of patients, although it is unclear whether or not the principal concern actually lies with the 'best interests' of the tribunal itself.
It should be noted that, in relation to review tribunals set up under the Criminal Code, the Law Reform Commission (1976) recommended some time ago that research be undertaken into their operations. No such work has been forthcoming other than some minor exploratory studies by the Department of Justice (Federal) (Savoia,1976; Gilmour,1976).

32: See, also, my general discussion in Chapter 2.

33: In addition, particularly in the case of Criminal Code review tribunals, there is a need to take account of the interests of the community at large. This issue involves the problem of predicting future conduct on the part of the patient. As I noted in previous chapters, this is a particularly thorny matter where questions of dangerousness may be pertinent. In this sense, the 'best interests' of the patient have to be weighed against the 'best interests' of the community. As I noted earlier this issue will not be pursued in this thesis.

34: Personal conversation with Mr. Jack Ohlson of the British Columbia Legal Services Society and Mr. Jerry Ziskrout of the University of British Columbia law school, (August,1980) both of whom are involved in acting as patients' appointees on mental health review panels.

35: See note 34 <u>Supra</u>.

36: See note 34 <u>Supra</u>. It will be apparent that this situation is similar to the 'patient welfare' approach to the delivery of legal services, discussed in Chapter 4.

37: Ms. Freda Fyles of Parkdale Community Legal Services, Toronto.

38: Shone's research was conducted in 1974 and involved observation of civil and criminal review board hearings supplemented by interviews with board members and lawyers acting for patients. In Criminal Code cases, she found that the boards of review operated in a strictly informal atmosphere, consisting of a 'round table' conference. Although the boards saw their role as both inquisitorial and quasi-judicial, no oaths were taken and the strict rules of evidence were not followed. Thus, although in all hearings counsel was present to represent the patient, his or her role was limited. The boards heard 'evidence' from the physician responsible for the patient, the patient, the patient's 'witnesses', the patient's relatives, and then any other interested parties. The patient's lawyer would then sum up and make recommendations (i.e. advance the patient's perception of need) following which the board would retire to deliberate. In civil commitment cases, the conduct of the tribunal (known as a Review Panel) was found to be even more informal. 'Evidence' was heard out of sequence and in a splintered/interrupted fashion. The panel held pre-hearing discussions in which the client's history was examined and, in the infrequent cases where patients were represented, the lawyer's role/impact was negligible (in 12 hearings observed, legal counsel appeared in only two cases).

VI. ACCOMMODATING PERCEPTIONS OF NEED: FURTHER ASPECTS OF LEGISLATION

It is apparent that the conflicts and confusion that surround the needs of mental health patients are reflected throughout Canadian mental health legislation; a proposition I have attempted to explore in the context of review tribunals. I have also attempted to show how, in redefining patients' needs as rights and enshrining such rights in legislation, an effort has been made to accommodate competing perceptions of patients' needs. The extent to which a compromise exists is, however, questionable; a situation that may be found elsewhere in the relevant legislation affecting mental health patients.

A review of current mental health legislation and the limited discussions of the impact and significance of the legislation indicates that, in addition to the issue of rights in relation to commitment, continued detention and case review, four main areas have received close attention (Standing Social Development Committee,1978; Bolton, *et al*,1975; Weisstub,1980; Gren, 1979; Swadron & Sullivan,1973; Sharpe,1979; Anand,1979). These are as follows:

1. rights in relation to treatment and the refusal of treatment;
2. rights in relation to the issue of competency;

3. rights in relation to protection from harm and the securing of redress where wrongs have been inflicted on patients; and
4. rights in relation to basic issues such as communication and visitation whilst in hospital.

Each of these areas will now be examined in the context of current, Canadian mental health legislation as it pertains to the civilly committed patient and an attempt will be made to determine the extent to which a compromise has been found between competing perceptions of need. In addition, the implications of the situation will be considered in the context of the evolution of legal services for mental health patients.

In the context of a right to treatment and a right to refuse treatment beyond the common law 'rights' discussed in Chapter 2, the content of legislation appears to be quite varied between the provinces. In general, it could be argued that an implied right to treatment can be found in the parts of some Acts dealing with administrative matters and/or the specification of 'standards', where the duties and responsibilities of hospitals and mental health authorities are spelled out. Similarly, controls on the possibility of 'warehousing' (that is, long term detention without an attempt being made to provide a treatment programme) are established by virtue of provisions dealing with compulsory periodic examinations and renewals of certificates coupled with the case review provisions discussed in Chapter 5. However, nowhere in

Canada are patients granted a clear and legislatively prescribed right to treatment.

A right to refuse treatment is similarly unspecified. In one province, a right to refuse a certain form of treatment (psychosurgery) is enshrined but this may be conditioned by the decisions of review tribunals. In general, the right to refuse treatment is dealt with in the context of the necessity to obtain a patient's consent to treatment before such treatment may proceed; an issue that is tied to the question of whether or not a patient is 'competent' and can give informed consent.

Table VI provides a breakdown of the content of legislation in the ten provinces as it pertains to the two issues at hand.

TABLE IV

LEGISLATIVELY PRESCRIBED RIGHTS TO TREATMENT AND TO REFUSE TREATMENT: CANADA 1980

Province	RIGHT TO TREATMENT				RIGHT TO REFUSE TREATMENT			
	Implied Duty of care	Prescribed Duty of Care	Right To Treatment	Silent	Absolute Right of Refusal	Conditional Right	No Right of Refusal	Silent
British Columbia		++						++
Alberta		++					++	
Saskatchewan				++			++	
Manitoba				++				++
Ontario	++					++		
Quebec				++			++	
New Brunswick	++							++
Prince Edward Island	++							++
Nova Scotia				++		++		
Newfoundland				++			++	

Firstly, in the context of a right to treatment it will be noted that, as mentioned above, no province has prescribed a clear right to treatment. Indeed, the legislation in five provinces is silent in relation to even prescribed or implied duties in respect of the standards of care and treatment that should be established and maintained. It should be noted, however, that in three of these provinces (Saskatchewan, Nova Scotia and Newfoundland), this responsibility has been passed to the Governor in Council who, as in the case of Nova Scotia, "...may make regulations...d) prescribing or relating to standards for buildings, equipment and physical facilities, staff requirements and qualifications, standards of care and treatment of patients...; (and)...e) respecting admission, treatment, care, conduct, management, and discharge of patients or any class of patients." (Sec.5 Hospitals Act SNS 1977 c.45). As such, some 'legislative' control is placed on the operations of hospitals even though the establishment of such control is subject to considerable discretion.

As Table VI indicates, the legislation in three provinces contains an implied duty to provide care and treatment although this is also subject to discretion. This is typically illustrated by the situation in Ontario where the Minister of Health may appoint advisors who may visit and inspect facilities to ensure that facilities, equipment, staff and the range of services provided are adequate and that standards of patient care are maintained (Sec.4 Mental Health Act SO 1978 c.50). It is worth noting, however, that the term 'standards of patient care' is not defined or otherwise expanded upon in the legislation and, ii) in provinces with this type of provision the Governor in Council is again vested with the discretionary power to make regulations determining the standards of physical plant and staffing in psychiatric facilities (but not the treatment and care of patients as was the case in Nova Scotia). (Sec.61 Mental Health Act SO 1978 c.50).

It is only in two provinces, then, that anything approaching a legislatively prescribed duty to provide care and treatment can be found. In this sense, although not specifying a 'right', by imposing a 'duty' the legislation is instructing that certain things be carried out. Where the duty corresponds with the 'rights' sought by a patient (or more appropriately a patients' organisation) such rights are effectively acknowledged and enshrined. In British Columbia this type of situation can be found in the provisions laying out the powers and duties of the directors of mental health facilities:

> "A director <u>shall</u> ensure that
> a)each patient in a provincial mental health facility is provided with professional service, care and treatment appropriate to his condition and appropriate to the function of the provincial mental health facility..."
> (Sec 8 Mental Health Act RSBC 1979 c.256)(my emphasis)

Similarly in Alberta:

> "Upon the admission of a patient to a facility a (hospital) board is under a <u>duty</u> to provide such

> diagnostic and treatment services as the patient is in need of and that the staff of the facility are capable and able to provide."
> (Sec.24 Mental Health Act RSA 1972 c.118) (my emphasis)

However, even where a duty is clearly established it must be noted that it is conditioned by the proviso that the duty be limited by the capabilities or function of the facility. No absolute standards of treatment are specified such that the duty is seemingly conditioned by the types of mental health facilities provided by the province.

It is thus apparent that nowhere in Canada are there absolute legal standards to ensure that a patient receives appropriate or adequate treatment. What constitutes adequate treatment is entirely within the discretion of hospital or mental health authorities and is therefore subject to their perception of patients' needs. Without a prescribed right to treatment and where a patient believes that he or she is not receiving adequate or appropriate treatment, it appears that he or she has no legal recourse (other than at common law) to challenge the treatment that is provided, ~~or~~ the lack of treatment. However, it may be possible, where inappropriate treatment or no treatment is administered, to make a claim for damages against the authority that is in breach of the prescribed statutory duty where such a duty is specified (Alper,1978).

Secondly, in the context of a right to refuse treatment or, perhaps more appropriately, the requirement that no treatment be given without the consent of a patient, it will be apparent that the situation is equally varied across the provinces. It must be noted that, in relation to this specific area of concern, the only type of patients affected are those who are involuntarily committed to facilities. Where a person is a voluntary patient (however that may be defined and however problematic that concept might be) he or she, by definition, will be consenting (at least in theory) to whatever treatment is given (Alper,1978).[1] Where an objection to a treatment modality is made and not responded to by the relevant personnel, the voluntary patient has the capacity (in theory) to simply leave the hospital if he or she is dissatisfied.

Whilst no absolute right of refusal is present in any Canadian legislation, in two provinces an (involuntary) patient has a conditional right to refuse treatment. In Ontario, no psychiatric treatment may be given without the consent of a patient although this is conditioned by a facility for a review tribunal to authorise such treatment as may be considered necessary by the hospital where a patient refuses (See Sec 31A, Mental Health Act SO 1978 c.50). Similarly, in Nova Scotia, a clearly specified right to refuse treatment; viz,

> "No person admitted to a hospital shall receive treatment unless he consents to such treatment,"
> (Sec 46(1) Hospitals Act SNS 1977 c.45)

is immediately conditioned in the case of those patients declared to be 'incapable' of consenting; a judgement placed in the hands of a psychiatrist at a hospital by virtue of Sec 44 of the Hospitals Act (SNS 1977 c.45). Whilst the Ontario provisions may afford a patient at least some right to challenge an attempt to impose treatment the situation in Nova Scotia appears less helpful. In the latter jurisdiction, a patient has to first appeal a declaration of incapacity before the issue of treatment becomes relevant although it does seem, as I pointed out earlier, that the provincial review tribunal may provide some avenue for appeal in relation to treatment issues, independent of the issue of competency/capacity.

Despite these shortcomings, the situation in these two provinces appears less Draconian than that prevailing in the four provinces where the legislation is silent in relation to the issue and in the four provinces where the legislation specifies that no consent is required. In the latter case, the situation prevailing in Alberta is typical. Under Sec 30 of the Mental Health Act (RSA 1972 c.118), "(t)wo admission certificates are sufficient authority to observe, examine, care for, treat, control and detain the person named therein..."(my emphasis) although it must be noted that the periods of time during which this can occur tend to be limited. That is, periodic re-certification is required before detention (and therefore, inter alia, treatment) may be continued irrespective of the patient's consent.

When both the right to treatment and the right to refuse treatment are combined as issues and considered across the provinces, a further picture emerges to perhaps indicate the dominance of psychiatric as opposed to lawyer-centred perceptions of patients' needs. Health needs as perceived by psychiatrists clearly over-ride legal needs as perceived by lawyers even though the latter may be related to the improvement of health care. As stated, no provinces have prescribed an unequivocal right to receive or refuse treatment. Of the two provinces that have prescribed a clear duty to provide care and treatment, one is silent in respect of refusal (British Columbia) whilst the other clearly permits treatment to occur without consent(Alberta). In the three provinces that have prescribed an implied duty to provide care and treatment only one has provided a conditional right of refusal (Ontario) whilst the other two are silent on the matter. Of the five provinces that are silent in relation to the provision of treatment, three allow treatment to occur without consent (Saskatchewan, Quebec and Newfoundland), one provides a conditional right of refusal (Nova Scotia) and the fifth is silent in respect of refusal (Manitoba).

The right to refuse treatment seems particularly pertinent where treatment may involve the use of psycho-surgery; a matter that has been subject to considerable debate centred around the moral and practical ramifications of such drastic treatment(Standing Social Development Committee,1978; Weisstub,1980). Some of this debate has tended to cloud the less spectacular aspects of the issue of a right to refuse treatment by deflecting attention away from the equally important question of the excessive use of chemo-therapy and other treatments (e.g. E.C.T.). For example, it is apparent that where 'concessions' are granted in the resolution of a conflict between competing perceptions of need in relation to treatment, psycho-surgery is offered out as a suitable sacrifice (Standing Social Development Committee,1978). As the sacrifice may already be dead, it could be argued that where rigid controls are placed on psycho-surgery the compromise is perhaps achieved at the expense of controls in more important areas. It may be achieved at the expense of controls that could be placed on less obvious, more frequently employed and possibly more important treatment modalities that are daily encountered by a broad cross-section of patients.

This issue aside, it is clear that in only two provinces have controls been placed on the use of psycho-surgery. It is interesting to note that both are jurisdictions where a conditional right to refuse treatment has been established by virtue of recently reformed legislation. Thus, in Ontario any form of psycho-surgery for involuntary patients is absolutely prohibited by Sec.31A of the <u>Mental Health Act</u> (SO 1978 c.50), whilst, in Nova Scotia such surgery is only permitted after stringent criteria are met including a review of the case by the review tribunal (Sec.52 Hospitals Act SNS 1977 c.45). The legislation in the other eight provinces is silent on the matter. Given that these are provinces with legislation that has not mentioned a right to refuse treatment or provides specifically for treatment to proceed without consent, the possibility of psycho-surgery occurring contrary to a patient's perception of need is high.

In a discussion of the foregoing issues, reference has been made to the questions of competency and capacity. For example, the issue of whether or not a patient is 'competent' affects the capacity that a patient may or may not have to give or refuse, consent to treatment. The assumption, it seems, is that where a patient is incompetent he or she cannot determine what is in his or her 'best interests'.

As several writers have argued (Gostin,1979a; Swadron & Sullivan, 1973; Roth,1979; Anand,1979; Weisstub,1980), the issue of 'competency' really precedes all other matters pertaining to mental health patients and their rights. If they are 'competent' there can be no justification for the involuntary deprivation of liberty or for the imposition of undesired treatment. It is, therefore, somewhat suprising that the issue of competency has not been subject to closer scrutiny in the context of securing and protecting patients' rights. This, it is argued, is possibly due to the tendency for competency matters to be considered only in the context of trusteeship or guardianship and the attendant emphasis upon 'protecting' a patient's assets or 'affairs' whilst he or she is, perhaps temporarily, unable to control such assets in his or her 'best interests' (Somerville, 1979). Certainly this latter concern is of considerable importance in its own right for with a declaration of incompetency a patient loses the right to control most aspects of his or her life (Price,1973; Standing Social Development Committee,1978; Gostin,1979a; McLaughlin,1979).

As Price has noted (1973), the actual meaning of the terms 'assets' or 'affairs' is unclear such that the power of a body entrusted with the care of a patient may extend beyond a simple concern with a patient's property or 'estate'. The terms may be interpreted to involve complete control over the patient extending far beyond a form of economic trusteeship. Certainly attempts have been made to specify the powers of 'guardians' or 'trustees' but, in general, these appear to extend rather than limit control.[2] In addition, as Price again notes (1973), it is questionable whether declarations of incompetency are solely for the 'benefit' of the patient. They may also benefit society by preventing the creation of a financial burden (e.g. by restraining the 'destruction' of assets) and by protecting the community from harm (e.g. by preventing a patient from using a motor vehicle). Clearly it is uncertain whose 'best interests' are considered of paramount importance.[3]

The ramifications of an incompetency order for individual patients have not escaped all attention and there is a noticeable trend developing towards introducing reform that involves, in particular, a more selective employment of declarations of incompetency (Somerville,1979; McLaughlin,1979). That is, the blanket declarations that tend to be a function of most current legislation are now being challenged by those who argue that an individual's 'competency' will vary according to the condition of the individual patient and the nature of his or her 'affairs'. For example, as Somerville has argued (1979):

> "Traditionally a functional test of competency in relation to managing one's estate was used as the basis for a declaration of legal incompetency, which, as a corollary, was often aimed at protecting the incompetent's property and not his person. Such a declaration, however, was generally regarded as rendering the person subject to it incompetent in all respects. This global effect should be re-examined and a person who is factually competent in regard to medical decision-making should not be deprived of this right. Rather, a person should only be declared to be totally legally incompetent where this is necessary to protect both his person and his property." (op cit:90)

As such, only flexible and individualised 'incompetency' orders can in any way adequately answer patients' needs in this area (Gordon,1980; Gostin,1979a; Standing Social Development Committee,1978; Price, 1973; Dewey,1965; McLaughlin,1979).

Further, as Morris indicates (1978), it is possible that incompetency orders are being employed to usurp those patients' rights that are enshrined in legislation (see, also, Morris,1980). In his study of the use of 'conservatorship' orders in California he found clear evidence that they are being used to negate certain provisions of the Lanterman-Petris-Short Act; a piece of legislation that has been heralded as the 'Magna Carta' of the mentally ill. As he argues:

> "Through the...conservatorship device, the conservator may 'voluntarily' admit his conservatee to a mental health treatment facility. Thus, involuntary treatment of non-dangerous individuals can be and is being achieved." (op cit: 400)

The extent to which a similar process occurs in Canadian jurisdictions is unknown. However, as I will indicate later in this chapter, the potential exists by virtue of the content of the relevant legislation.

It is apparent that exposures of such problems have yet to have a marked impact on legislation in the ten provinces.[4] However, just as involuntary commitment and continued detention have been made subject to review in some jurisdictions, so too have declarations of incompetency and incapacity. As a result, at least some control is placed on the process of declaring patients incompetent or incapable although, as is apparent in the case of the foregoing issues, psychiatric opinion can be seen to dominate decision-making in respect of initial assessments and, perhaps, subsequent reviews.[5] Whilst this may be acceptable in the context of treatment and other purely medical matters, it may be challenged in other circumstances. Where the issue of competency is concerned with the administration of an estate, business or other economic entity it could be argued that a specialist skilled in such matters is better equipped to determine whether or not a patient is capable of making decisions in his or her 'best interests'. Further, as Dewey(1965) and Leifer(1963) have noted, the problem of predicting outcomes found in relation to criminal law matters (see, in general, Weisstub,1980) is once again apparent. As no systematic and satisfactory tests of competency exist, questionable judgements are applied that may result in unjust conclusions particularly where procedural safeguards are absent (Dewey,1965).[6]

It is apparent that three issues are of importance to mental health patients in this area: i) the process by which decisions in relation to competency are made; ii) the effect of such decisions; and iii) the mechanisms by which a patient may recover his or her status (Price,1973).[7] Table V provides a breakdown of the situation across the ten provinces in relation to these issues.

TABLE V

CAPABILITY, COMPETENCY AND CAPACITY AND PATIENTS' RIGHTS: CANADA, 1980

Province	DECLARATION OF INCAPABILITY/ INCOMPETENCY/INCAPACITY			EFFECT OF DECLARATION			RESTORATION OF STATUS			
	Psychiatric Certification on Admission	Court Declaration	Administrative Notification	Guardianship, Committee or Tutor	Public Trustee, Currator or Administrator	Court Supervision	Apply to Review Tribunal	Apply to Court	Psychiatric Revocation of Certification	Appeal of Original or Subsequent Orders to a Court
British Columbia		++		++	++			++		++
Alberta	++	++		++	++		++	++	++	++
Saskatchewan	++				++		++		++	++
Manitoba		++		++	++			++		
Ontario	++			++	++		++		++	
Quebec	++			++	++		++		++	
New Brunswick	++			++	++		++		++	
Prince Edward Island	++			++	++		++		++	
Nova Scotia	++			++	++		++	++	++	
Newfoundland		++	++	++		++		++		

It will be apparent from Table V that considerable variation exists between the different jurisdictions. In seven provinces, a patient may be examined by a psychiatrist (or any physician) on being admitted to a psychiatric facility to determine whether or not, in addition to the question of mental illness, the patient is capable, competent or has the capacity (herein after referred to as 'competent') to manage his or her 'affairs'. This power is typically portrayed by Sec 32 of the Ontario, <u>Mental Health Act</u> SO 1978 C.50):

> "Forthwith upon the admission of a patient to a psychiatric facility, a physician shall examine the patient to determine whether or not he is competent to manage his estate."

Following such an examination (which, in general, may also occur at anytime during a patient's hospitalisation) and assuming he or she finds that the patient is incompetent, the physician then completes a certificate to that effect which is passed directly (and sometimes at great speed) to a Public Trustee, Administrator or similar public body. The public body then immediately 'assumes management' of the patient's 'affairs', the effect of which will be discussed shortly.[8]

The apparent ease with which a patient may lose control over his or her affairs can, it is argued, be seen as perhaps the most important issue in the area of patients' rights. At the same time, it is the one receiving the least attention. The basis upon which judgements are made by psychiatrists appear to be unspecified in most legislation although it should be noted that in completing a certificate of incompetency the certifier is required to justify his or her judgement. Such justification, however, need only be broadly spelled out, the physician being required to do nothing more than describe and distinguish between those facts he or she 'observes' and those communicated by others. As a consequence it is possible that certification may be completed on the basis of a perhaps questionable judgement on the part of a psychiatrist and hearsay 'evidence'. To be sure, in one province, Nova Scotia, an effort has been made to give direction to the types of issues to be considered when the certifying physician is making his or her judgement. However, this has not, it is argued, been a terribly effective exercise; indeed the legislation is less than helpful in protecting patients from poor or arbitrary judgements.

The provisions of Sec 44 of the Hospitals Act (SNS 1977 c.45) dictate that the issues of capability ~~to~~ consent to treatment and competence to administer an estate are to be treated as separate matters, each having a set of criteria by which a psychiatrist is required to make his or her judgement. In the context of treatment, the psychiatrist must assess whether or not the patient, a) understands the condition for which the treatment is proposed, b) understands the nature and purpose of the treatment, c) understands the risks involved in the treatment, d) understands the risks involved in <u>not</u>

undergoing the treatment and , e) is suffering from a condition which affects his or her ability to consent. The inclusion of the last item seems to add a tautologous quality to the criteria, for in effect it is saying that in assessing whether or not a person is capable of consenting the certifier should consider whether or not the patient is in a condition such that he or she has the ability to consent. Presumably if the patient was not perceived to be suffering from such a condition the issue would not have arisen in the first place. The circular nature of this provision is somewhat puzzling.

To some extent the provision dealing with the issue of competency to manage an estate is less problematic:

> "In determining whether or not a person is competent to administer his estate, the psychiatrist examining the person shall consider:
> a) the nature and degree of the person's condition;
> b) the complexity of the estate;
> c) the effect of the condition of the person upon his conduct in administering his estate; and
> d) any other circumstances the psychiatrist considers relevant to the estate and the person and his condition.
> (Sec.44(3) <u>Hospitals</u> <u>Act</u> SNS 1977 c.45)

Although not tautologous, the provision requires a psychiatrist to make judgements that are beyond his or her professional capabilities. The 'complexity of (a person's) estate' may be an issue best assessed by an accountant or business consultant. Similarly, attempting to correlate an individual's condition with a prediction of competency in the context of an estate may, as I have pointed out, be an activity as fraught with difficulty as attempts to predict 'dangerousness'.

In some provinces, the reliance upon the judgement of a psychiatrist is apparently considered unsound or inappropriate and is replaced by a court hearing. As Table V indicates, in British Columbia and Manitoba, a patient can only be declared 'incompetent' by an appropriate court, whilst in Alberta and Newfoundland this process supplements either psychiatric judgement (in the case of Alberta) or a simple administrative notification (in the case of Newfoundland).[9] Where a court becomes involved in the declaration of competency, substantial protections are provided for a patient. Psychiatric judgement simply becomes an issue to be assessed by the court and can thus be subjected to critical appraisal. The traditional features of the adversary system are present such that where a patient wishes to contest an application he or she may do so and receive a full hearing on the matter. As a consequence, the individual needs of the patient may be determined in an atmosphere that takes cognisance of the nature of both the patient's illness (e.g. its possible duration) and the nature of his or her 'affairs'.

The impact of a declaration of incompetency is such that the issue of the accuracy and sensitivity of judgements pertaining to the declaration cannot be treated lightly. As will be noted in Table V, in most provinces a declaration may lead to either the appointment of a guardian, committee or tutor, or as is more often the case, the person's affairs will pass into the hands of a Public Trustee, Administrator or Curator who acts as Committee for the patient. The type of court supervision provided in Newfoundland is rather unusual in that it offers levels of supervision or management according to the value of the estate;[10] however it can, generally speaking, be validly discussed in the context of Public Trusteeship.

Although most legislation prescribes the power of a guardian, trustee or similar body, to assume management of the 'estate' of a person, the powers invested generally involve more than those seemingly necessary to simply manage an estate as an economic or commercial entity. At this point, it must be noted that this area of law is extremely complex and subject to considerable variation between the provinces. What follows is, therefore, only a very general discussion of the effect of a declaration of incompetency, concentrating on some central issues.

In general, a patient loses complete control over his or her affairs and also control over accessing mechanisms by which he or she can assess the extent to which the body managing the affairs is acting in his or her 'best interests'. Certainly, the relevant legislation lays down stringent rules for the management of a patient's estate, including a provision for periodic inspection of specific records; however this is largely aimed at ensuring that monies and/or property are not dishonestly misappropriated rather than ensuring that the patient's 'best interests', <u>per se</u>, are being served. In addition to these losses and as I noted earlier, a patient may lose the right to refuse treatment; in effect, a patient loses control over his or her body.

In the context of the 'estate' of a patient the <u>absolute</u> nature of the power that is passed to a trustee or other body is typically portrayed by Sec. 42 of the Ontario <u>Mental Health Act</u> SO 1978 c.50:

> "The Public Trustee as committee of a patient or out-patient has and may exercise all the rights and powers with regard to the estate of the patient or out-patient that the patient or out-patient would have if of full age and of sound and disposing mind."

Within fairly broad parameters the managing body has complete control over all matters relating to the patient and his or her affairs.

In general, any power of attorney awarded to another party becomes void and the entire management of an estate passes to the Trustee who is entitled to receive remuneration from the estate for the 'management' services. In addition, the Trustee may make payments for the maintenance of a patient, to the facility in which the patient is being treated and for the maintenance of the patient's family or other dependents. These additional matters may seem reasonable and sensible, however in the case of payments to the facility housing the patient, they involve the abrogation of what might be seen to be the only remaining power of a patient to control what happens to him or her; particularly where the patient believes that the services being provided by a facility are not suitable or effective. A patient cannot refuse to pay for services that he or she finds unsatisfactory presumably because he or she is perceived as being unable to make such a judgement. Given that, under more conventional circumstances, a patient who declines to pay for hospital or other medical services would quickly find that such services are suspended, an 'incompetent' patient is not afforded such a 'privilege' (or right). Thus, in the context of a right to treatment, an incompetent person is not allowed the possibility of controlling the quality of treatment by employing economic sanctions against those providing the services.

Similarly no economically based controls can be placed on the conduct of the trustee or committee who may exercise the power invested by virtue of the declaration of incompetency in any way they may see fit. That is, so long as an estate is lawfully 'managed', no other responsibilities are imposed on the trustee or committee; for example, acting to assist in the restoration of a patient to a competent status. Only the province of Alberta has, to some extent, attempted to provide controls on the direction of the trustee's management. Rather than simply allocating a blanket power to the patient's committee (in Alberta this body is known as a 'guardian') the recently proclaimed Dependent Adults Act (SA 1976 c.63) attempts to impose more stringent duties on those exercising the allocated authority. As Sec.11 states:

> "A guardian shall exercise his power and authority
> a) in the best interests of the dependent adult, and
> b) in such a way as to encourage the dependent adult to become capable of caring for himself and of making reasonable judgements in respect of matters relating to his person."

Here, notwithstanding the use of the problematic term 'best interests', we see a requirement that the committee do more than simply manage a patient's affairs. They are duty bound to do all that they can to encourage a person to continue to manage his or her affairs. This seems to be a clear recognition of the importance of the concept of 'normalisation' in the 'treatment' of mentally ill persons[11] and represents an attempt to restore rights to a patient as well as, to some extent, providing a denunciation of management practices that simply ignore any patient-centred perceptions of need or fail to canvass such views.

As useful as this particular Alberta provision may be, an 'incompetent' person may encounter difficulties when and if he or she attempts to 'enforce' the prescribed duty as an independent person. In keeping with the situation in all provinces, a declaration of incompetency and the attendant passage of 'management' to another, involves the loss of a right to undertake independent legal actions. The simplicity with which this right is removed by legislation is typically portrayed by Sec 22(1) of the British Columbia, Patients' Property Act (RSBC 1979 c.313):

> "No person other than the committee of the patient shall bring an action on behalf of the patient."

And, in a typically qualified form, by Sec 43 of the New Brunswick, Mental Health Act (RSNB 1973 c.M-10):

> "No person, other than the Administrator of Estates, shall bring an action ...without the leave of a judge of a court in which the action is intended to be brought..."

In both instances, it can be seen that a patient declared incompetent is deprived of free access to the courts even where such independent access may be necessary to protect a patient's estate or to enforce a duty.[12]

Finally, in this area, a declaration of incompetency may remove any right (both that which is prescribed by legislation and that which is available at common law) that a patient has to refuse treatment. By virtue of being declared incompetent, a patient is deemed not to have the ability to consent to treatment or decline treatment. As a consequence, this power may be passed to the trustee, committee, guardian or other body ascribed authority. As I argued earlier, it appears that in most provinces a right to refuse treatment simply does not exist for involuntarily committed patients. Legislation either gives a psychiatric facility a right to treat irrespective of the patient's wishes or is silent on the matter. Even in those provinces where consent is required it may, in the case of an 'incompetent' patient be obtained from a guardian, trustee or committee with the blessing of a review tribunal.[13]

It can thus be seen that a declaration of incompetency will have a profound and far-reaching effect on a patient. Indeed, although it is closely tied to the issue and process of hospitalisation, the impact of a declaration can extend beyond any period of detention in hospital. A trustee, committee or other body may continue to control a patient's affairs after release from hospital presumably because such release is not necessarily equated with restored competency. In general, this power is to be found in all ten provinces and is typically portrayed by Sec.11 of the British Columbia, Patients' Property Act (RSBC 1979 c.313):

> "...the Public Trustee may continue as committee of the estate of any person who has been discharged from a provincial mental health facility or psychiatric unit, and may retain the control and administration of the person's estate, so long as it is in his opinion necessary or desirable in the interests of that person or of his estate."

A patient or ex-patient's right to control his or her own affairs may, therefore, remain in supension for an indefinite period.

The enormity of the ramifications of a declaration of incompetency seems to be reflected in the attempts to provide mechanisms by which a patient may appeal a declaration or seek the restoration of a 'normal' status. As Table V indicates, in those provinces where the judgement of a psychiatrist or physician can lead to certification as an 'incompetent' person, a power of revocation is invested in the same individual. Thus just as certification can lead to declaration so revised certification can lead to restoration.[14] In addition, and perhaps more importantly, in the same jurisdictions a patient has a right to apply to a review tribunal for a hearing on the matter.[15] However, as I indicated in my discussion in Chapter 5, this does not necessarily mean that a hearing will actually take place. This shortcoming is off-set in two provinces (Alberta and Nova Scotia) where a patient has the additional right to apply to a court for restoration and thereby take advantage of an opportunity to have the matter considered in an adversarial rather than informal context.[16] In three provinces (British Columbia, Manitoba and Newfoundland) where declarations of incompetency are made by courts, restoration is, similarly, a matter for the same courts. Further, in three provinces (British Columbia, Alberta and Saskatchewan) an additional right of appeal to a court in relation to any declaration or refusal of revocation is provided.

In summary it can be seen that, in general, patients can be declared 'incompetent' with relative ease. The effect of such a declaration is quite profound having an impact on a patient's right to control his or her own 'affairs' in the context of both matters pertaining to an 'estate' and matters pertaining to their own welfare(i.e. in respect of treatment). In addition, limitations are placed on the right to take independent legal action. A patient's status, in general, is restored by a reversal of the process of declaration with the added possibility of applying for a review tribunal hearing and/or appealing to a court. It is an area of patients' rights which has received only limited attention despite, a) its centrality in mental health law, and b) the impact that a declaration can have on a patient's life. This seems to be due to the fact that the issue of competency is generally associated with trusteeship as an 'economic' entity when, in actuality, it can involve more far-reaching issues (Somerville,1979).

It is argued that, in the main, legislation in this area demonstrates a preference for the psychiatric-centred perception of patients' needs. This is particularly apparent in the context of treatment issues. At the same time however, there is an acknowledgement of lawyer-centred perceptions of need, particularly where they do not conflict unduly with, or otherwise challenge, the doctrine of <u>parens</u> <u>patriae</u>. In this respect it must be noted that the use of courts for the determination of competency matters and other deliberations in the 'best interests' of a patient is by no means new (Venables,1975). Whilst lawyers may be attempting to use the court in an effort to protect patients' interests and advance their perceptions of need, it could be argued that they seem to be doing so without challenging the basis upon which such mechanisms are founded, notably the concept of 'best interests'. On the other hand, it could be argued that they are simply reworking existing 'rights' to the benefit of patients, the alternative (a further utilisation of psychiatric judgements) being less acceptable. In any event, patients' perceptions of need seem to be dwarfed by the conflicting perspectives held by psychiatrists and lawyers both of whom are eager to ensure that their view of the 'best interests' of patients is served. By definition, of course, the patient is not deemed competent enough to join in the contest.

In the course of the discussion on competency, reference was made to the fact that upon the appointment of a trustee, committee or guardian to manage a patient's 'affairs', a patient loses the right to seek independent legal action in relation to any matter. This right may also be strictly limited by mental health legislation, independent of the issue of competency. As I indicated in Chapter 2, this is a matter of considerable concern to lawyers involved in 'mental health' law in Commonwealth jurisdictions because, where they exist, such restraints confound efforts to; a) seek redress where a patient has been wronged; and b) 'enforce' the few rights that exist for patients (both those legislatively prescribed and those existing at common law). At the same time, however, attempts have been made to provide patients with alternative protective mechanisms. Legislation in some of the provinces contains provisions making it an offence for mental health staff and others to mistreat, neglect, or otherwise abuse, patients. Similarly, legislation has sought to protect possible infringements of those patients' rights that have been enshrined in legislation by, again, providing negative sanctions where such rights are denied or frustrated. It is argued, however, that these provisions have a more symbolic than deterrent effect and do not allow any individual redress or compensation for a patient who may have suffered at the hands of hospital staff. As such they do not provide the patient with protection from harm or allow a patient to secure redress where wrongs have been inflicted.

Table VI provides a breakdown of the situation across the ten provinces in relation to these issues.

TABLE VI

LIMITATIONS ON ACTIONS AND LEGISLATIVE PROTECTION OF PATIENTS/PATIENTS' RIGHTS: CANADA, 1980

	LIMITATIONS ON ACTIONS AGAINST STAFF AND OTHERS				GENERAL PROTECTION OF PATIENTS/RIGHTS			SPECIFIC PROTECTION OF PATIENTS/PATIENTS' RIGHTS			
Province	No Liability if Acting Under Relevant Act	Relief of Liability Limited to Specific Circumstances	No Actions Without Authority	Time Limit on Any Actions	Offence to Breach any Provision of Act	Fine	Fine/Imp.	Offence to Ill-Treat, Neglect or Assault	Offence to Obstruct/ Deny Rights	Fine	Fine/Imp.
British Columbia		‡						‡			‡
Alberta									‡	‡	
Saskatchewan		‡	‡	‡	‡	‡					
Manitoba	‡	‡	‡		‡		‡	‡			‡
Ontario				‡	‡	‡					
Quebec					‡	‡					
New Brunswick			‡	‡	‡	‡					
Prince Edward Island			‡	‡	‡	‡					
Nova Scotia					‡	‡					
Newfoundland								‡	‡	‡	

It will be noted that, with the exception of Manitoba, blanket limitations on the liability of mental health administrators or personnel are not a feature of Canadian mental health legislation.[17] However, in some provinces, certain persons acting pursuant to certain duties prescribed in the relevant legislation may be relieved of liability. This situation is typically portrayed by Sec. 16 of the British Columbia, Mental Health Act (RSBC 1979 c.256):[18]

> "No person is liable in damages as the result of
> a) signing an application or laying an information,
> b) signing a medical certificate or making a report if he is a physician.
> c) signing an order if he is a judge;
> d) issuing a warrant if he is a justice; or
> e) transporting or taking charge of a person on the authority of applications and medical certificates which on their face are lawfully completed in good faith and with reasonable care."

In two provinces (Saskatchewan and Manitoba), the pursuit of actions that may be permissible is further limited by the requirement that, before any action is commenced, permission must first be obtained from an higher authority. Such a limitation is found in two other provinces (New Brunswick and Prince Edward Island) where it applies to any proceedings that may be proposed against mental health staff. The comprehensive nature of such provisions is typically illustrated by Sec. 66(1) of the New Brunswick Mental Health Act(RSNB 1973 c.M-10):[19]

> "No action, prosecution or other proceedings shall be brought or be instituted against any officer, nurse, clerk, attendant or other employee of a psychiatric facility, or against any other person, for an act done

> in pursuance of execution or intended execution of any duty or authority under this Act or the regulations, or in respect of any alleged neglect or default in the execution of any such duty or authority, without the consent of the Minister of Justice."

A further, special time limitation is imposed on actions in three provinces, and also applies in a fourth province (Ontario) where no other restraints appear to exist. As Price argues (1973), such time limits may destroy any chance of pursuing an action in particular because alleged wrongs may not come to light immediately after they occur. Such a limitation is typically illustrated by Sec.58 of the Ontario Mental Health Act (SO 1978 c.50):

> "All actions, prosecutions or other proceedings against any person or psychiatric facility for anything done or omitted to be done in pursuance or intended pursuance of this Act or the regulations shall be commenced within six months after the act or omission complained of occurred and not afterwards."

In New Brunswick and Saskatchewan, a similar time period is specified[20] whilst in Prince Edward Island this is extended to twelve months.[21] It is thus apparent that, in only four provinces (Alberta, Quebec, Nova Scotia and Newfoundland), no limitations of any type are imposed on actions sought against persons acting under or pursuant to, mental health legislation.

Where limitations have been imposed, some attempts have been made to provide alternative protections for patients. In seven provinces, legislation has created a specific offence for any person to breach any of the provisions of the relevant legislation. Whilst this type of inclusion governs procedures in relation to all aspects of commitment, continued detention, certification, transfer, and so on, it can also be seen to protect those patients' rights that may have been enshrined in the legislation. This is typically portrayed by Sec. 67 of the Nova Scotia, Hospitals Act(SNS 1977 c.45):[22]

> "Any person who violates or fails to observe any provision of this Act or the regulations is liable on summary conviction to a penalty of not more than five hundred dollars and in default of payment, to imprisonment for not more than ninety days."

Thus where, for example, patients have been prescribed certain rights in relation to applying for case review and these rights are denied or obstructed by 'any person' (such as a mental health professional) the relevant party may be committing an offence and be liable for certain 'punishments'.

As can be seen, in Nova Scotia, the specified penalty is a modest fine which might have a deterrent effect on those in a position to deny or obstruct rights. However, in other provinces, the possible punishment may be less effective. In Saskatchewan and New Brunswick, for example, the maximum fine is $100 whilst in Quebec an individual offender (as opposed to a 'corporation') can only be fined up to $200. It should be noted, however, that in other provinces the possible punishments for infringement are more severe. In Ontario a contravention of any provision of the Mental Health Act or regulations attracts a maximum fine of $10,000 whilst, in Manitoba, a maximum fine of

$500 is accompanied by an alternative penalty of up to one year's imprisonment.

In four provinces, provisions for the general protection of legislatively enshrined patients' rights are replaced or, as is the case in Manitoba, supplemented by, more specific protections. In British Columbia, Manitoba and Newfoundland a specific offence has been created with the apparent purpose of protecting patients from harm. This is typically portrayed by Sec.17(2) of the British Columbia Mental Health Act(RSBC 1979 c.256):[23]

> "A person employed in a provincial mental health facility or a private mental hospital or any other person having charge of a patient who ill-treats, assaults or wilfully neglects a patient commits an offence punishable under the Offence Act."

In Newfoundland the offence attracts a maximum fine of $500, in Manitoba a maximum fine of $500 or up to one year imprisonment whilst, in British Columbia, an offender can receive a fine of up to $2000 and/or imprisonment for six months.[24] In addition to such protection, legislation in Newfoundland and Alberta includes provisions dealing with the protection of specific rights and imposes moderate pecuniary penalties for offenders.[25]

It could be argued, then, that although some limitations are placed on the capacity of mental health patients to take action against mental health administrators or staff (notably in the province of Manitoba), the presence of provisions protecting patients from general and specific harms as defined by legislation outweighs such limitations. An effort has been made to 'criminalise' not only breaches of patients' rights but also behaviour that may be specifically associated with the vulnerable position of patients (i.e. the provisions dealing with neglect, ill-treatment and abuse).[26] In some places, the related punishments can be considered severe although this is certainly not the case in the provinces of Saskatchewan, New Brunswick and Quebec.

Quite what impact the penalties have on mental health staff and administrators remains unknown. Doubtless some general deterrent effect[27] exists where fines are high and are accompanied by the possibility of imprisonment but such severity does not appear to be a feature of the penalties in all provinces. Further, no enforcement or complaints mechanisms appear to accompany the relevant provisions such that where a patient has no resources outside an institution and/or is, perhaps, intimidated by errant staff, the likelihood of discovery is slim. Even where incidents of physical abuse or the abrogation of rights comes to light, it is feasible that such matters are dealt with by low-visibility, disciplinary processes within the institutions, rather than criminal prosecution under the mental health legislation or the Criminal Code. Such 'protective' provisions do not assist a patient in obtaining damages to compensate for any wrong that may have been effected nor do they protect patients' needs that have not been re-defined as 'rights'.

This area again presents a confused picture in relation to the effect of competing perceptions of patients' needs. On the one hand, there is an obvious reluctance to 'criminalise' actions that involve the antithesis of the psychiatric-centred perceptions of patients' needs (neglect and abuse cannot be equated with care and restored health). Indeed, in some provinces, the legislation is more concerned to criminalise the behaviour of people who assist or attempt to assist, patients to 'escape' from hospitals than the behaviour of those who ill-treat patients.[28] As mental health staff are the only people in a position to ill-treat, abuse or neglect a patient clearly such a situation can only be to their advantage. Some restraints are also placed on the pursuit of actions against mental health professionals and others, presumably to protect such persons from vexatious litigation. Given that, with the development of legal services for patients most litigants would be seeking actions through lawyers, this type of provision seems to suggest that lawyers do not place some quality control on litigation. As I pointed out in Chapter 4, the 'strict instructions' of clients are subjected to a filtering process that already effectively excludes any unnecessary or unreasonable legal actions from the courts. Under these circumstances, further controls can only serve to hamper legal services and benefit recalcitrant mental health staff or authorities. In this respect, the legislation seems to be accepting psychiatric perceptions of need (including, perhaps, a perception of their own needs) over and above the perceptions proferred by lawyers and their patients/clients.

On the other hand, general and specific protective provisions exist to ensure that persons who do not comply with the spirit and direction of the legislation are subject to negative sanctioning. This includes those who deny or obstruct patients in the exercise of those rights that have been enshrined in legislation. In this respect the legislation has, apparently, been designed to assist in the protection of patients' needs, notably where general needs have been re-defined as rights. It is unfortunate that so few rights exist to be so protected. As such, what appears to be an acknowledgement of patients' perceptions of need may in fact be an empty gesture.

Finally in this chapter I will itemise and discuss other rights that are found in legislation across the ten provinces; that is, rights in relation to such basic issues as communication and visitation whilst a patient is in hospital. It is perhaps rather curious to have to consider the extent to which elementary rights such as communication and visitation are established and at the same time limited by, mental health legislation. In general, any person entering a hospital under conventional circumstances would not be placed in a situation where contact with their life outside the institution is threatened. Such continued contact is, after all, a 'right' only denied to those placed in penal institutions as one of the pains of imprisonment. In general, mental health patients are subject to the same type of control for whilst basic rights are enshrined these are, in the main, promptly limited.

The rights to communication and visitation tend to underpin all other rights for, without them, a patient may be restrained from making contact with resources outside an institution; resources that can aid the patient in appreciating his or her rights and also provide assistance in enforcing or protecting such rights. Further, as has been noted, communication with the 'outside' world is a form of therapy which should not be subjected to any restriction (Standing Social Development Committee,1978). It is, in effect, an essential aspect of the health needs of patients as perceived by patients and, indeed, some mental health professionals (*op cit*). Perhaps it is in this area that the dominance of contradictory, psychiatric perceptions of patients' needs is most apparent for the rationale for restraints in the case of mental health patients tends to lie in the context of *disruptions* to therapy (*op cit*).

To some extent, limitations are also imposed to protect persons outside the institution from the receipt of offensive material and, it may be argued, unreasonable impositions on their lives. It may be that in certain cases such limitations are justified. For example, a patient who regularly mails parcels of faeces to near relatives or writes and sends obscene and offensive letters to strangers may be justifiably restrained. However, as in the case of incompetency issues, we tend to find blanket restraints on all patients rather than an individually orientated process of control. In addition, in one province (Alberta) the likelihood of such occurrences does not seem to have been considered sufficient to justify any form of restraint. Table VII provides a breakdown of the established rights and accompanying limitations, across all provinces.[29]

TABLE VII

MISCELLANEOUS PATIENTS', RIGHTS AND ATTENDANT LIMITATIONS: CANADA, 1980

Province	RIGHT TO RECEIVE MAIL		RIGHT TO SEND MAIL		RIGHT TO USE TELEPHONE		RIGHT TO REASONABLE VISITATION		RIGHT TO BE INFORMED OF RIGHTS	
	Unlimited	Limited	Unlimited	Limited	Unlimited	Limited	Unlimited	Limited	General Notice	Written Notification
British Columbia										
Alberta	++		++					++		
Saskatchewan		++		++						
Manitoba		++		++						
Ontario		++		++						
Quebec		++		++						++
New Brunswick		++		++						
Prince Edward Island										
Nova Scotia		++	++							
Newfoundland						++	++		+	++

It will be noted that three provinces are silent in relation to the range of rights I have itemised.[30] This is qualified in the case of Newfoundland for in that jurisdiction the issue of controls on communication is passed to the Regulations associated with the legislation under Sec 24 of the <u>Mental Health Act</u> (SN 1971 c.80). As a result, some rights may be established but also limited, at the discretion of the Lieutenant Governor in Council.

In six provinces, a limited right to <u>receive</u> mail has been enshrined. This is typically portrayed by Sec 62 of the Nova Scotia <u>Hospitals Act</u> (SNS 1977 c.45):

> " 2) No mail sent to a person under observation or a patient shall be opened or withheld, nor shall its delivery be obstructed or delayed, except that the administrator or his designee may be present at the opening of the mail and may remove contents of the mail detrimental to the addressee or others but not the correspondence itself.
> 3) Notwithstanding subsection (2), no mail shall be withheld from a person under observation or a patient unless in the opinion of a psychiatrist it would be detrimental to that person or patient."

Here we find considerable discretion in the hands of mental health staff. No attempt is made to define the term 'detrimental' although there is an implicit assumption that it is to be considered in the context of the health needs of a patient.[31] In some provinces, the limitation is not extended to mail believed to have been sent to a patient by specified people or agencies. For example, in Ontario, mail sent by a barrister and solicitor, a member of a review tribunal or a member of the

Legislative Assembly cannot be opened, examined or withheld,[32] whilst, in New Brunswick, the list is extended to include the Ombudsman.[33]

A corresponding (limited) right to send mail has been established in five provinces, restraints apparently being imposed to protect both the patient and persons who are likely to be in receipt of mail. Perceptions of the needs of two groups are thus under consideration. This is typically illustrated by Sec. 19 of the Ontario, Mental Health Act (SO 1978 c.50):

> "1) Except as provided in this section no communication written by a patient...shall be opened, examined or withheld, and its delivery shall not in anyway be obstructed or delayed.
> 2) Where the officer in charge or a person acting under his authority has reasonable and probable cause to believe,
> a) that the contents of a communication written by a patient would,
> i) be unreasonably offensive to the addressee, or
> ii) prejudice the best interests of the patient...
> ...the officer in charge or a person acting under his authority may open and examine the contents thereof and, if any condition...exists, may withhold such communication from delivery."

As in the case of the receipt of mail, exceptions to the limitations exist where mail is being sent to certain people or agencies.[34]

In the province of Alberta, no limitations are placed on the patient's right to receive and send mail.[35] Similarly in Nova Scotia, whilst a patient's right to receive mail is limited, the right to send mail is unlimited. Clearly, in both provinces, the welfare of the potential recipients of mail and the health needs of the patient are considered to be less important than a patient's right to uninhibited communication. Indeed, in Nova Scotia, the right to communicate is given further impetus by a complementary right to be given access to appropriate materials for the purpose of writing.[36]

The variations that exist between provinces are puzzling. If the rationale for restraints on the receipt of mail lies with a serious concern for a patient's treatment programme, it might be expected that a limitation would exist in each province. Similarly if there was a high risk of patients offending or in someway affecting the lives of people outside an institution, or threatening their own 'best interests', by sending mail then again a certain uniformity might be expected. The lack of such uniformity can only undermine the justifications for any type of limitation on the basic right to unimpeded communication.

It is also apparent that only one province (Nova Scotia) has enshrined an unlimited right to make or receive telephone calls. Legislation in other provinces is silent on the matter. In addition only two provinces have dealt with the right to receive visitors at reasonable times. In one province, this is an unlimited right (Nova Scotia) whilst in the other (Alberta) this right may be suspended if a physician considers that a visitor would be detrimental to a patient's health.[37]

In only two provinces (Quebec and Nova Scotia), efforts have been made to ensure that patients understand their rights.

In Quebec, Sec 27 of the Mental Patients Protection Act (SQ 1972 c.44) requires that a written notification of rights be given to patients. This procedure is followed in Nova Scotia where there is also a requirement that material respecting rights be posted "in a place within the hospital where it can be seen by persons under observation or patients."[38] As has been argued, the posting of notices may not, alone, be an entirely satisfactory way of advising patients of their rights (Standing Social Development Committee,1978). Such notices may be placed on a cluttered noticeboard, no effort being made to draw a patient's attention to the notice. Indeed, it is also argued that simply handing a notice to a patient may be no better. The individual may be sick, drugged or so worried that the document is not read; a problem that can only be overcome by the presence of an independent person in the institution who can advise patients and protect patients' rights (op cit).

An analysis of the extent to which rights to communication, visitation and notification have been established but also limited, reveals a less than uniform picture across the ten provinces. In most jurisdictions, the legislation is either silent in relation to such rights or imposes limitations which can be applied at the discretion of mental health staff. In an ideal situation, patients should have an unlimited right to receive and send mail backed by a right to be given access to writing materials. They should have a right to receive and make telephone calls and an unlimited right to receive visitors. In addition, an institution should have a duty to inform patients of their rights and to ensure that patients have a clear understanding of them. Certain aspects of this base line are clearly considered reasonable in some jurisdictions in Canada. Indeed, if the legislation in Nova Scotia and Alberta were collapsed together and adopted as a standard or model for all other provinces then the ideal situation would exist. Where patients' rights in these areas are either ignored or only accepted on a piecemeal basis, protections are substantially and unjustifiably reduced. Although possibly not the intention of legislators, the failure to provide the complete spectrum of rights as outlined above could lead to the suggestion that those rights that do exist are intended to be symbolic gestures rather than genuine attempts to protect patients from arbitrary and unjustifiable restraints on extremely basic civil rights in the name of their health needs.

The somewhat basic overview of the situation affecting mental health patients in the ten provinces, provided in this Chapter and Chapter 5, demonstrates, it is argued, three things:

1. Although considerable advances have been made in establishing patients' rights (that is, pursuing lawyer-centred perceptions of need), the general situation is neither consistent nor satisfactory. The fact that some provinces appear willing to accept and enshrine some

protective rights whilst others have paid only scant attention to the issue is curious but perhaps reflects the extent to which effective and energetic lobbying has occurred in the different jurisdictions. It may also reflect the ideology of mental health authorities in the different provinces in that where a sympathetic 'regime' exists reforms will be easier to effect. Indeed the reforms may stem from the mental health authorities themselves rather than solely from patients' consumer groups. At this stage the question is moot although a closer examination of the evolution of legislation in Alberta and Nova Scotia would probably assist in securing an answer.

2. In general, mental health legislation tends to reflect psychiatric-centred perceptions of patients' needs. There is also some evidence to suggest that it reflects psychiatric-centred perceptions of psychiatrists' needs. With few exceptions the discretions given to mental health staff are extensive, the rationale clearly being that such discretions are necessary to answer the health needs of patients. Although the effect of lawyer-centred perceptions of need (particularly those representing patients' organisations) can be seen, the impact is tempered by the content of a compromise that appears to be weighted towards the 'health' needs of patients. This suggests that whilst legal needs in the context of 'rights' are acknowledged as

legitimate they are ascribed a more symbolic than effective status. It appears that whilst the goal of balancing health and legal needs has been sought, in the process of weighing competing opinions the benefit of any doubt has gone to the psychiatric, rather than legal, lobby.

3. Legal need has been both created and continued by mental health and related legislation. In particular, the establishment and expansion of review procedures has created a need, and a more clearly defined role, for lawyers. The failure to enshrine and protect rights provides a situation in which continued action by legal workers can only thrive. Patient and lawyer-centred perceptions of need seem to remain largely unanswered and, as a result, efforts to convert such perceptions into rights will continue. The newly created and the continued, legal needs will have to be met by legal services.

This third and final issue provides a glimpse of both an evolutionary process in the provision of legal services and the effect that legislation may have on that process. I will turn, in the final chapter, to discuss the evolutionary process and to offer some comments on possible future directions for legal services, particularly in Commonwealth jurisdictions.

NOTES

1: The problems associated with the concepts of voluntariness, consent, and informed consent are legion. As many writers have noted (e.g., Stone,1979b; Gostin,1979a; Grosman & Summers,1980; Mason,et al,1978; Owens,1977; Roth,1979; Singer,1977; Somerville,1979), a fine line often exists between voluntariness and consent and coercive persuasion. Similarly, the extent to which consent is actually 'informed', even where no coercion is employed, may be questioned. Such doubt extends beyond the mental health setting to most professional/client relationships.

2: In Alberta, for example, Division 2 of The Dependent Adults Act (SA 1976 c.63) lays out the extensive powers given to a 'guardian'. These include, making decisions in relation to where a 'dependent' is to live, with whom he or she is to live, whether or not he or she can engage in 'social activities', and whether or not he or she shall be permitted to work. In addition a guardian can control education, applications for licences, legal actions and the dress and diet of the dependent. Power is also given in relation to all aspects of 'health care'.

In Saskatchewan, on the other hand, legislation has taken great care to limit powers to matters pertaining only to estates. (See, Mental Health Act RSS 1965 c.345 (as amended)).

3: This issue again raises the 'public interest' element in mental health and related legislation mentioned in earlier parts of the thesis. Again this aspect will be regretably by-passed.

4: A possible exception exists in the case of Nova Scotia where recently revised legislation attempts to control the criteria by which judgements are made and which draws a distinction between capacity and competency in the contexts of treatment and the management of 'affairs'.
(See Secs 43 to 46 Hospitals Act SNS 1977 c.45).
Similarly, in British Columbia, where incompetency can only be declared by the Provincial Supreme Court, a distinction is made between incapacity in respect of the management of a person's 'affairs' and incapacity in respect of the management of the patient by him or herself (notably applying in the case of the aged).
(See Sec 2, Patients Property ActRSBC 1979 c.313)
(See, also, Sec 46 The Dependent Adults Act SA 1976 c.63 (effective Dec.1st 1978)).

5: It is also clear, as I indicated in Chapter 5, that review proceedings may not be an effective protection. As Grant has noted (1978), even where an 'adversarial' hearing is available, the actual conduct of such hearings may do little to protect patients.

6: See, also, my discussion of the concept of 'best interests' in Chapter 4.

7: It should be noted that this is a rather complex area of law, a full exposition of which would be beyond the scope of this thesis. In general, a person does not have to be admitted to a psychiatric facility before he or she can lose control over his or her 'affairs'. Such a loss can occur at any time, under a range of circumstances, whenever a person is considered by another to be 'infirm' and incapable of acting in their own 'best interests'. For example, an aged person or someone seriously ill in hospital could be declared incompetent. As such the issue of mental illness is only one aspect (but perhaps the most commonly experienced) of the process of declaring persons incompetent and making arrangements for the management of their 'affairs'. In general, legislation in the provinces acknowledges this fact and the issue is frequently dealt with by legislation independent of that governing mental health matters, _per se_, or in conjunction with such legislation. See, for example, _Patients Property Act_ RSBC 1979 c.313; _The Dependent Adults Act_ SA 1976 c.63; <u>Infirm Persons Act</u> RSNB 1973 c.13.

8: Ontario; Secs. 32 to 35, <u>Mental Health Act</u> SO 1978 c.50
Alberta; Sec.35 <u>Mental Health Act</u> RSA 1972 c.118; Secs. 50 to 68 <u>The Dependent Adults Act</u> SA 1976 c.63.
Saskatchewan; Sec 21 <u>Mental Health Act</u> RSS 1965 c.345.
Quebec; Secs. 8 to 10 <u>Mental Patient Protection Act</u> SQ 1972 c.44.
New Brunswick; Secs 35 to 40 <u>Mental Health Act</u> RSNB 1973 c.M-10
Prince Edward Island; Secs 30 to 35 <u>Mental Health Act</u> RSPEI 1974 c.M-9.
Nova Scotia; Secs.43 to 46 <u>Hospitals Act</u> SNS 1977 c.45.

9: This provision, it is argued, is perhaps even more questionable than those pertaining to psychiatric judgement. Under Sec.20 of the <u>Mentally Incompetent Person's Estate Act</u> (RSN 1970 c.234), the superintendent of a hospital is required to notify the Registrar of the Provincial Supreme Court of every person committed to the hospital together with information relating to the person's estate and family. On receipt of the notice, the Registrar becomes the guardian of the patient's estate. The provision requires no specific examination of a patient in the context of competency and as such seems to suggest that commitment to hospital automatically assumes incompetency; a process which is seen as blatantly absurd

(Price,1973). It must be noted, however, that in this province the Supreme Court plays a more central role in managing a patient's estate and the patient can apply directly to the court for restoration of status. Under such circumstances, any objection may be swiftly heard and a declaration of incompetency tested in an adversarial context.

10: See Secs 16 to 19, Mentally Incompetent Persons' Estates Act SN 1970 c.234.

11: This concept was discussed in Chapter 3.

12: It should be noted that this restriction is additional to that found in some mental health legislation where actions against any person acting under the provisions of the legislation may be stayed or prevented. A fuller discussion of this issue follows next in this chapter.
In British Columbia, the power of the Public Trustee in this area was successfully challenged in Rosandik v Manning [1978] 5 BCLR 347, but only in the context of a patient's right to apply to the Supreme Court for release under the then Sec 30 Mental Health Act SBC 1974 c.29. The effect of the judgement is limited to similar cases arising under the provisions of the British Columbia Mental Health Act.
In Prince Edward Island, a judgement in another case imposed

some limitations on the powers of trustees and committees. In Mackay v Mackay (1975) 24 RFL 216, a divorce case involving an 'incompetent' respondent, the Supreme Court (Family Division) ruled that an official trustee had no jurisdiction to interfere on 'behalf' of a patient, his authority extending only to matters involving a patient's estate. Here we have some indication that the courts wish to interpret the term 'estate' in its strict sense and also limit the powers of a committee over legal actions sought to be pursued by, or otherwise involving, an incompetent person.

13: A recent case, in Prince Edward Island, indicates that, at least in the context of drastic and irreversible surgery, a declaration of incompetence and the appointment of a committee may not necessarily mean that a patient loses all rights to refuse treatment. In Re E (1979) 19 RFL (2d) 317, the Provincial Supreme Court established the right of a 'mental retardate' to the "inviolability of her person from involuntary trespass", such a right superceding the "right to be protected from pregnancy". The mother of a mentally incompetent woman successfully applied to be appointed her committee and then authorised a sterilisation (tubal ligation). The appeal against the authorisation was upheld by the court.
In this general context, it is of interest to consider the extent to which drastic non-treatment of an incompetent person

may also be opposed. In the United States cases of *Re Quinlan* 7[illegible] NJ 10 (1976); 355 A 2d 647 (1976), and *Supt. of Belchertown State School v Saikewicz* 370 NE 2d 417 (1977), the question of whether or not a patient's guardian has the power to instruct non-treatment that may lead to death was extensively debated. In the latter case, a Probate Court appointed as the guardian of Saikewicz authorised the withholding of medical treatment arguing that as he was terminally ill with leukemia it was in his 'best interests' to die. The authority was opposed and although the issue became moot because of Saikewicz's death it was clear that, in general, such decisions in incompetency cases should always be made by courts and not guardians.

The issue raised by both these cases is perhaps a little distant from the situation normally prevailing in relation to mental health patients. However the *Quinlan* and *Saikewicz* cases involve, in part, a conflict between two opposing notions of how to determine what is in the 'best interests' of an incompetent patient in relation to treatment (or non-treatment) decision-making. On the one hand, as in *Quinlan*, a medical prognosis model was seen to be the most appropriate mechanism, whereas in *Saikewicz* 'substituted judgement' was preferred (see also *Re Boyd* 403 A2d 744 (1979), discussed in Chapter 4; Annas,1979; Baron,1978; Relman,1978). The debate, therefore, is pertinent to the mental health area for situations may arise where guardians and psychiatrists come into conflict in relation to the treatment of a declared incompetent; a conflict that may have to be resolved by the courts.

14: Ontario: Sec 36 Mental Health Act SO 1978 c.50.
Quebec: Sec 10 Mental Patients Protection Act SQ 1972 c.44.
Nova Scotia: Sec 49 Hospitals Act SNS 1977 c.45.
Prince Edward Island: Sec 33 Mental Health Act RSPEI 1974 c.M-9.
New Brunswick: Sec 39 Mental Health Act RSNB 1973 c.M-10.
Alberta: Sec 54 Dependent Adults Act SA 1976 c.63.
Saskatchewan: Sec 21 Mental Health Act RSS 1965 c.345.

15: Ontario: Sec 39 Mental Health Act SO 1978 c.50.
Quebec: Sec 46 Mental Patients Protection Act SQ 1972 c.44.
Nova Scotia: Sec 50 Hospitals Act SNS 1977 c.45.
Prince Edward Island: Sec 35 Mental Health Act RSPEI 1974 c.M-9.
New Brunswick: Sec 42 Mental Health Act RSNB 1973 c.M-10.
Alberta: Sec 63 Dependent Adults Act SA 1976 c.63.
Saskatchewan: Sec 42 Mental Health Act RSS 1965 c.345.

16: Sec 67 Dependent Adults Act SA 1976 c.63.
Sec 50 Hospitals Act SNS 1977 c.45.
The advantages of taking this course of action have been discused in the context of commitment and continued detention.

17: Sec. 94(2) Mental Health Act SM 1965 c.48.

> "No action lies or shall be instituted; against any person, whether in his public or private capacity, where that person is acting under the authority of this Act, for any loss or damage suffered by any person by reason of anything done by him in good faith, or omitted to be done by him in the exercise of powers given to him by this Act."

18: See, also, Sec 31 Mental Health Act RSS 1965 c.345; Sec.95 Mental Health Act SM 1965 c.48.

19: See, also, Sec 52 Mental Health Act RSS 1965 c.345 (an action may be stayed on application to a judge of the Court of Queens Bench for Saskatchewan or of the District Court). Sec.96 Mental Health Act SM 1965 c.48 (an action may be stayed on application to a judge of the Court of Queens Bench for Manitoba, if it is believed that the action is vexatious). Sec.56 Mental Health Act RSPEI 1974 c.M-9. (as per Sec.66(1) RSNB 1973 c.M-10).

20: Sec 66 Mental Health Act RSNB 1973 c.M-10.
Sec 53 Mental Health Act RSS 1965 c.345.

21: Sec 56 Mental Health Act RSPEI 1974 c.M-9.

22: See, also, Sec 56 Mental Health Act RSS 1965 c.345.

Sec 105 Mental Health ActSM 1965 c.48.

Sec 57 Mental Patients Protection Act SQ 1972 c.44.

Sec 67 Mental Health ActRSNB 1973 c.M-10.

Sec 58 Mental Health Act RSPEI 1974 c.M-9.

23 : See also, Sec 21 Mental Health Act SN 1971 c.80.

Sec 103 Mental Health Act SM 1965 c.48.

24: Sec.4 Offence Act RSBC 1979 c.305.

25: Sec 21 Mental Health Act SN 1971 c.80; dealing with obstructing the right of patients to 'communicate' with the review tribunal (maximum fine of $500).

Sec 50.1 Mental Health Act RSA 1972 c.118; dealing with the unlawful disclosure of information relating to patients (protects the right to privacy and confidentiality) (maximum fine of $500).

26: Yake has suggested (1976), that this particular type of provision could be applied more broadly. Such 'neglect' clauses might be used to penalise those who disregard an implicit 'right' to treatment. As tantalising as this possibility might be, it is doubtful whether it would receive support in the courts.

27: General deterrence seems to be the principal objective of punishment in this context. Hopefully any finding of guilt in relation to a member of staff would lead to dismissal and the impossibility of employment in the occupation again. Thus specific deterrence is effected by a process of protection through exclusion.

28: It could be argued that this is because, in general, ill-treatment or abuse of patients may be dealt with under the Criminal Code and does not require a special provision in mental health legislation. Assisting a patient to 'escape' is not, however, a situation that is covered by the provisions of other legislation and therefore needs to be specifically provided for. The presence of the provision simply tends to reinforce the 'penal' quality of involuntary commitment.
The following is a breakdown of the situation across the provinces.

TABLE VIII

AID/ABET ESCAPE PROVISIONS: CANADA 1980.

Province	Aid/Abet Escape Provision	Penalty	Ill-Treat/ Neglect Provision	Penalty
British Columbia	Sec 17(1), RSBC 1979 c.256	$2000 fine, up to 6 mths. imprison.	++	$2000 fine, up to 6 mths. imprison.
Alberta	---	---	---	---
Saskatchewan	Sec.55,RSS 1965 c.345	$25-100 fine	---	---
Manitoba	Sec.101,SM 1965 c48	$500 fine or 1 yr imprison.	++	$500 fine or 1 yr imprison.
Ontario	Sec.21(5)SO 1978 c.50	$10,000 fine	---	---
Quebec	---	---	---	---
New Brunswick	Sec 24(5) RSNB 1973, c.M-10	$100 fine	---	---
P.E.I.	Sec.19(5) RSPEI 1975, c.M-9	$25-$500 fine	---	---
Nova Scotia	---	---	---	---
Newfoundland	Sec.11(3) SN 1971 c.80	$500 fine	++	$500 fine

Clearly a certain imbalance exists. Seven provinces have provisions dealing with aiding and abetting 'escapes', but only three provinces have provisions in relation to the ill-treatment, neglect, etc. of patients.

29: It should be noted that this discussion is restrained entirely to rights and their attendant limitations found in mental health legislation. As many writers have pointed out, limitations may be placed on numerous other civil rights by way of legislation dealing specifically with civic and other functions. For example, a patient may lose the right to vote, to hold a driving licence, and to hold public office. A complete analysis of these issues is beyond the scope of this thesis but a full discussion can be found in Swadron & Sullivan,1973 and Weisstub,1980.

30: These rights represent all ancilliary rights not previously discussed in these Chapters. Thus it does not include rights in relation to review hearings, such as the right to obtain access to hospital records (and the corresponding right to confidentiality of records), the right to apply for a hearing, the right to cross examine, etc. Nor does it include rights in the areas of treatment, competency and protection from harm. It does, however, include the right to be informed of rights which, whilst associated with review tribunals, is a right extending to cover all issues.

31: This is clearly expressed in Sec 19(2) of the Ontario Mental Health Act SO 1978 c.50. Mail may be examined and the contents withheld if the authorised staff member has "reasonable and probable cause to believe" that the contents would,
i) interfere with the treatment of the patient, or
ii) cause the patient unnecessary distress.

32: Sec 19(3) Mental Health Act SO 1978 c.50.

33: Sec 19(3) Mental Health Act RSNB 1973 c.M-10.
See, also, Sec 29 Mental Patients Protection Act SQ 1972 c.44.
Sec 97 Mental Health Act SM 1965 c.48.
Sec 54A Mental Health Act RSS 1965 c.345.

34: See notes 32 and 33 above.

35: Sec 44 Mental Health Act RSA 1972 c.118.

36: Sec 62 Hospitals Act SNS 1977 c.45.
See also, Sec 97 Mental Health Act SM 1965 c.48.

37: Sec 62 Hospitals Act SNS 1977 c.45.
Sec 45 Mental Health Act RSA 1972 c.118.

In Alberta, however, a solicitor acting for a patient may visit the patient at any time.

38: Sec 62 <u>Hospitals Act</u> SNS 1977 c.45.

VII. THE EVOLUTION OF LEGAL SERVICES FOR MENTAL HEALTH PATIENTS

It is apparent that considerable attention is now being paid to the developments that are occurring in the general relationship between both law and psychiatry (as fields of study) and lawyers and psychiatrists (as interacting professionals), in society (Stone,1975; Weisstub,1980; Allen,*et al*,1975; Brooks,1974; Barton & Sanborn, 1978). In this thesis, I have attempted to examine and discuss *one* aspect of this larger process by concentrating on the evolution of legal services for mental health patients, particularly in Commonwealth jurisdictions. In doing so, I have tried to demonstrate the close relationship between the mental health law and legal aid movements.

Both groups have essentially evolved together as an area of sub-specialisation within the practice of poverty law, at the same time interacting with (and to some extent perhaps encouraging) developments and changes that are occurring in the evolution of mental health care. All this suggests, not only a "system in transition" (Stone,1975), but also a system in 'evolution' that is passing through an epoch characterised by considerable conflict and intense upheaval. Although history will be the ultimate judge, it is possible to predict that a synthesis will emerge from the current, antithetical situation.

Indeed, as I suggested in Chapter 2, some indication of such a synthesis is beginning to appear in the United States and will inevitably flow over into Commonwealth jurisdictions. This suggests that, to transcend an essentially passive, Hegelian determinism, we may be in a position to shape developments by appreciating the essence of specific evolutionary factors, rather than perpetually reflect upon our knowledge of what was. Given that the process of legal service personnel in interaction with mental health professionals provides something of a practical, rather than purely theoretical, contribution to the general developments, both groups may be in a position to consciously condition the content and form of the evolutionary process. By considering the situation legal services presently confront and by reflecting on 'what-has-been' for the legal aid/poverty law movement, it may be possible, in a crude and perhaps rather grandiose sense, to induce Hegel's Owl of Minerva to spread its wings in the dawn rather than the dusk. Such an exercise may be truly in the 'best interests' of mental health patients. In general, this group seems to be excluded from the dialogue that surrounds the evolution of law and psychiatry, yet is caught between the Scylla of psychiatrists and the Charybdis of lawyers both of whom claim to be acting in patients' 'best interests'.

The evolution of legal services for mental health patients in Commonwealth jurisdictions is, clearly, influenced by a number of factors. I have already discussed the effect of legislation pertaining to the client group and have also suggested that, in the context of legal aid structures, developments are affected by relevant policies governing client eligibility and case coverage.[1] These last two matters are obviously tied to fiscal considerations. Similarly, in the context of mental health care, developments are linked to changes that occur in relation to treatment techniques and settings which are also bound by economic constraints. The current and well-documented trend towards community-based treatment programmes (see, e.g. Pardes & Pincus,1980; Steadman,1979a; Lamb,1979) will have an effect on perceptions of patients' needs held by all relevant groups and, as a corollary, on the extent to which the pursuit of some patients' rights continues to be necessary (e.g. the right to treatment in the least restrictive setting). Indeed, it is essential in pursuing patients' rights that their eventual establishment does not obstruct innovative and constructive developments that may have occurred or be occurring, independent of aggressive advocacy (Stickney,1974). In this respect, it must be recognised that the establishment of patients' rights does not necessarily require legislative enactment. They can be both recognised and respected by relevant parties; indeed, a simple acceptance of such rights as an unquestioned entity or normative condition may be a faster and ultimately more flexible way of attaining the goals inherent in the 'rights'.

However, at this stage in the evolution of mental health law and legal services, such a simple acceptance appears some distance away. This is particularly true of Commonwealth jurisdictions even though, as I have argued, legislation in Canada has attempted (in some places) to find a compromise between competing perceptions of patients' needs and thereby establish a situation that is 'acceptable'. In doing so, however, legislators seem to have created a confused and inconsistent situation that can only breed further conflict between different perceptions of the health and legal (notably civil rights) needs of patients.

Although, as I have noted,[2] considerable agreement appears to exist between perceptions of need held by lawyers, psychiatrists and patients it is clear that the establishment of some form of consensus is elusive. It has been suggested that this may be due to internecine warfare between lawyers and psychiatrists, a consideration that is especially valid in the face of the possibility that a major source of objection and therefore obstruction, lies in the context of a patient's 'right' to be involved in decision-making <u>vis-a-vis</u> treatment.[3] That is, the right to advance and have recognised as legitimate, his or her perception of his or her own needs. Essentially, such a right ascribes competency to a patient; a condition that appears as an anathema to psychiatric-centred perceptions of patients' needs and, perhaps, psychiatric-centred perceptions of psychiatrists' needs. As I indicated in Chapter 4, the relationship between psychiatrists and patients is characterised by the assumption that a patient is a 'child'. As a consequence, the professional is the best person to determine what is in the patients's 'best interests'. In this setting the patient is powerless.

Clearly it would be absurd to argue that all patients are always competent to make valid judgements. Similarly, however, the reverse proposition - no patient is ever competent - is equally invalid. Perhaps what is required is a recognition that many patients can make valid judgements and should have the right to determine what is in their 'best interests' in a health care context.[4] This, however, involves the insertion of the element of 'patient power' into the doctor/patient relationship that has, traditionally, been one involving domination and dependency. As Somerville notes (1979):

> "...that the patient has...power,...is usually legally and morally true. That the doctor...has power,...is often more factually realistic."(op cit:30)

Through the doctrine of consent, the doctor is forced to perceive the patient as a "fellow citizen", a situation that weakens the power of the doctor over the subject (op cit). Where consent is legally negated through the declaration of incompetency, only a moral objection to dominance remains; an objection that is erased by the concept of 'best interests'.[5]

As a threat to the continuation of such a relationship is posed by lawyers acting for patients, one might expect some 'friction at the interface' (Barton & Sanborn, 1978) that emerges as internecine warfare. This situation serves to cast some light on an issue at the heart of the evolution of legal services for mental health patients that in turn reflects, I would argue, the '<u>leit-motif</u>' of the legal aid/poverty law movement.

As Lasswell & Kaplan argue (1965):

> "Power is participation in the making of decisions...(and is)...a property which can belong to a person or group...The making of decisions is an inter-personal process; the policies which other persons are to pursue are what is decided upon. Power as participation in the making of decisions is an inter-personal relation...(it) is, specifically, a deference value: to have power is to be taken into account in others' acts (policies)."(<u>op cit</u>:75-77)

'Rights' and power are essentially symbiotic. Where power is denied to a particular group or where an imbalance exists in the degree of power held by potentially competing or interacting groups and such a situation leads to perceived injustice or inequity, it can only be redressed through the establishment of rights. Legislation may have to carry out such a task where other efforts (e.g. mutual recognition and acceptance) prove fruitless.

Although, as I have suggested, there may be some uncertainty on the part of legal aid/poverty law practitioners in relation to the needs of clients, there is a strong and consistent belief in the primacy of the concept of power. As I noted in Chapter 3, the legal aid/poverty law movement has developed from a platform of social action that would, it was hoped, change the situation surrounding the poor. It would provide them with, <u>inter alia</u>, access to a resource that could introduce an element of power into and over, their lives. As Galanter has argued (1975), this involves transforming the 'have-nots' from the status of 'one-shot' players to that of 'repeat players'; that is , providing them with power when confronting existing systems and structures experienced in the utilisation of law to protect their own 'property' interests (Reich,1964).[6] Such power would create at least equity in the relationship between the poor and other social groups or agencies. In particular, in the guise of social welfare law, it would act to counter-balance the power of those tribunals, officials and other bodies that have arisen to administer one aspect of an expanded government largess (the distribution of 'income' to disadvantaged groups) (Reich,1964). The extent to which this goal has actually been achieved is moot(Girth,1977; Haveman,1977). However, in extending its interest from the poor, <u>per se</u> to other disadvantaged groups, the legal aid/poverty law movement has also persisted with the theme of providing such groups with access to power. In this respect, mental health patients are no exception.

In the growth of the legal aid/poverty law movement generally, the process of establishing power can be seen as a factor that conditions the delivery style adopted by practitioners. As I have argued, in the context of mental health patients/clients, legal service delivery styles fall along a continuum between a 'strict instructions' approach associated with aggressive, partisan advocacy, and a more conciliatory, 'patient welfare' approach.[7] This in turn tends to reflect a similar continuum that appears to exist in the legal aid/poverty law movement as a whole. Aggressive advocacy exists at one pole and a more mediatory 'social work' approach at the other. As the legal aid/poverty law movement has evolved, in a global context, it is apparent that a particular delivery style has dominated at any given time in different places. In essence, the 'style' or approach taken has been, indeed is, a product of the situation prevailing in different jurisdictions in relation to the establishment and acknowledgement of rights (and therefore power) or the informal recognition of the need for equity in relationships between disadvantaged groups and 'opposing' 'repeat players'.

In general, there is an apparent move towards the 'social work' approach (Grace & Wilkinson,1978; Harte,1974; Byles & Morris,1977; Phillips,1979; Zander,1978; Pfennigstorf & Kimball,1976) even though objections may be raised that this is not a proper role for legal aid/poverty law practitioners in specific contexts (Gostin & Rassaby,1980). To a certain extent this change may be due to a recognition that partisan advocacy for the poor has not been entirely successful and that, as a consequence, an alternative strategy or approach must be adopted in an attempt to attack poverty from a 'social work' rather than legal action/reform, angle. Such a possibility is perhaps the case in Commonwealth jurisdictions where the legal aid/poverty law movement appears to have reached a plateau without the 'achievements' in relation to rights, associated with United States colleagues. On the other hand the move away from purely partisan advocacy may also be seen as the emergence of a new phase in legal aid/poverty law delivery that is a direct result of the benefits obtained by aggressive advocacy.

In this sense, benefits can be seen in both the establishment of rights and in relation to the informal recognition of need on the part of relevant agencies who have responded in a positive fashion, independent of the establishment of rights. In the latter respect the so-called 'failure' of the legal aid/poverty law movement must be re-assessed. Whilst it may not have been entirely effective in creating visible, widespread reform (which was, in any case, only vaguely conceptualised at the outset) its impact at an individual level has been of immense and probably immeasurable assistance to many thousands of clients (Johnson,1978) and has established many informal 'precedents' of benefit to the client group as a whole.[8]

By working to achieve this situation, the legal aid/poverty law movement has paved the way for an approach that will allow the effective emergence of what I have argued is an essential aspect of the delivery of poverty law, namely, "...a practising technique that collapses a division of professional labour especially in relation to the distinction between work traditionally viewed as performed by a lawyer and that performed by the social worker."(Bothmann & Gordon,1979:18). Such a process is necessary because "...poverty law cannot be seen as an object for...practice in the traditional way. Rather it is a combination of things: law, innovative delivery, legal exploration, social work, political and legal advancement and education. It is not just a category of law; it is a category of action."(op cit).

In this context, aggressive partisan advocacy is, and has been, a vital approach to take in answering the legal needs of the disadvantaged. It involves a rigorous assertion of the needs of clients who, because of their powerlessness, have been either ignored or treated with a mixture of paternalism and contempt. In order for the needs of such clients to be taken seriously it seems to be imperative to demonstrate that such clients have 'teeth'; that they have access to 'repeat players' who can match the power of 'opposing' groups. Respect for the needs or 'rights' of the disadvantaged emerges through the effective but perhaps deliberately 'one-eyed', pursuit of their legal interests. Such a process sets the scene for less conflictual action that can only proceed once an equity of power is established in relevant relationships.

Effectiveness, in this sense, need not necessarily involve the creation of change as a direct result of legal action; it can, as I have indicated, be present in an indirect form through what has been described as the 'nuisance' value of certain forms of legal activity, or the 'fear' that an action may actually succeed (Gifford & O'Connor,1979; Bazelon,1969; Partington,1979). As Partington argues (1979) a 'failure' in a legal action may, nevertheless, lead to an important 'behavioural' change on the part of relevant agencies. In this sense, the goal of an action is achieved even though the action itself may have failed. Conversely, where a successful action results in the establishment of 'rights', it may in fact be little more than a 'paper' achievement (Bradley & Clarke, 1976). In short, legal 'defeat' may often result in greater gains than legal 'victory'.[9] The memory of the group's ability to pursue and protect its interests can extend beyond the immediate situation. As such it serves to ensure that any power that might be established is not eroded by a belief that the client group does not have the capability to once again 'bare its teeth' in defence of its needs and interests.

This suggests, I would argue, the presence of an evolutionary process in relation to the legal aid/poverty law movement. Such a process involves, first, the aggressive assertion of needs. Secondly, this is followed by either an establishment of rights or an informal recognition and acceptance of rights (an allocation of power). Finally, this situation is, in turn, followed by a process of moderation in 'demands' once power is equitably established.[10] For the latter condition to be maintained, however, it is necessary for the group involved to continue to have access to visible, aggressive advocates so that no attempt is made to dissolve their power. In this sense, partisan advocates may play an important deterrent role. The general process indicates that a change has to eventually occur in the delivery style adopted by <u>partisan</u> advocates. It is not a change, however, that should be perceived as involving a reversal to a former state of client powerlessness. In a dialectic sense, the situation has been irreversably altered as a result of the work of partisan advocates. In a practical sense, they still have a role to play in providing a resource of last resort when either more mediatory approaches fail, or attempts are made to subvert the established power base of clients.

This suggests that, once an effective balance or a 'functional equilibrium' has been established in the pursuit of power, an element of moderation may become necessary. The relentless and uncontrolled pursuit of needs and/or rights, beyond this point, may in fact sour any achievements. It may publicly devalue the efforts where they are deemed to involve 'trivial', 'unjust', or 'unrealistic' goals or, as is the case in the context of mental health patients, where they begin to be perceived as having a deleterious effect on the complete spectrum of clients' interests and needs.[11] For the legal aid/poverty law movement, determining the point at which an equilibrium is established may be difficult especially as practitioners do not appear to have a clear idea of what action is required in order to achieve the necessary reform (Haveman,1977). In the most general sense, they may hold the belief that the establishment of power is important and, similarly, be able to identify specific relationships where an infusion of power is required to benefit clients(e.g. in relation to government tribunals dealing with social welfare matters). However, beyond these individual settings their broader task is as vague and ill-defined as the nature of any functional equilibrium.[12]

In the specific context of mental health patients, however, this may not be entirely the case. It is clear that, in this area of sub-specialisation, the locus of conflict and therefore the contest for rights and power lies in the apparent contradiction between health and legal (notably civil rights) needs. The location and substance of a functional equilibrium is therefore readily identifiable. Of course, the point at which such a condition is established is necessarily bound to the situation prevailing in relation to individual clients/patients rather than the group as a whole. That is, to select an extreme, for some patients health needs may be paramount because of the urgent, extreme or chronic nature of their illness. In such cases, it could be argued that any balance between competing perceptions of need must fall towards medical rather than legal (civil rights) considerations. However, this is not the case for all patients, even though the extent to which such circumstances may exist is hard to determine with precision.[13] As such, an effective compromise between health and civil rights needs may be a relevant and generally attainable, goal.

In the context of the delivery of legal services for mental health patients, this seems to have been realised and involves a major concern with establishing, through the concept of rights, patient power in the relationship between patients and mental health professionals. As such, it means a process of overcoming the influence of the doctrine of parens patriae that has tended to dominate interactions between the two groups. As Lasswell & Kaplan might argue (1965), it involves increasing the degree of participation in the making of decisions by improving the 'weight' of power held by patients. This concern seems to reflect, very clearly, the views expressed by patients' organisations. As one group has argued,

> "(f)undamental to improving health care is a redistribution of power so more people have more control over their lives, their health and their health

services."(Peoples Health Bulletin,1978a:1)[14]

Similarly it is an issue that is recognised by some bodies making official recommendations in relation to changes to mental health systems. The British Columbia Mental Health Planning Survey (1979), for example, felt that efforts should be made to develop a system that would, inter alia, enhance patient self-determination.

> "Clients should retain the fullest possible control over their own lives. As much as possible, they should set their own goals and participate in planning programs to reach these goals." (op cit:Appendix)

Paradoxically, it may be a quest for a situation that is now attainable because of the advances in psychiatric medicine that have released mental health patients from the constraints of grossly disabling illnesses. With such a release has come a demand that the 'saviours' relinquish their supremacy over the 'saved' and ascribe them full equity in the distribution of power over decision-making. It is tempting to suggest that where this is interpreted by mental health professionals as a process of 'biting the hand that feeds you,' considerable resentment may develop. It is a resentment that may be converted to stubbornness and antagonism towards those who encourage the 'liberated' to turn against the 'liberators'. Herein, perhaps, lies the locus of any internecine warfare between lawyers and psychiatrists.

In the context of an evolutionary process affecting legal services for mental health patients, this quest for patient 'power' may be, as is the case in relation to the legal aid/poverty law movement as a whole, the principal factor determining the pace and direction of conflict. As such it conditions the eventual emergence of a synthesis that, *inter alia*, might channel energies in a more positive fashion. This is not to suggest that the current turmoil does not have its positive aspects. The vigorous airing and testing of opinion during conflicts is a positive process in a democratic context in the same way that any synthesis arising from conflict will, in itself, be a positive development. However, where conflict continues, unabated, for an excessive period because of an apparent *impasse* born of stubbornness, then one must question the value of the process as well as the motives of the relevant actors. Are they, for example, truly concerned just with the 'best interests' of mental health patients?

In the absence of voluntariness on the part of mental health professionals a balance of power in their relationship with patients may only be established by the vigorous pursuit of patients' rights on the part of their advocates. Once basic rights are attained, that is, once power is established for patients, and the situation is acknowledged and accepted by mental health professionals as a normative state of affairs, a different legal service delivery style, perhaps with an approach more orientated towards 'patient welfare', may become possible.

As I have argued, in Commonwealth jurisdictions (as illustrated by the situation in Canada), patients' rights are still largely absent from or restrained by, relevant legislation and, as far as can be seen, are generally discounted, in an informal context, by mental health professionals. As such, and given that the '<u>leit-motif</u>' of the legal aid movement is reflected in patients' legal services, it is necessary to continue an aggressive partisan advocacy approach to answering the legal needs of patients. This will continue until such time as generally recognised 'standards' in relation to rights, are obtained. In this respect the current stage of the evolution of legal services in Commonwealth jurisdictions, namely aggressive, partisan advocacy, seems likely to persist with only a distant glimmer of developments yet to come.[15]

This can only be a regrettable state of affairs especially given the fact that, as I noted in Chapter 4, mechanisms for dealing with the 'conventional' legal needs of patients may actually complement health care. However, where 'legal services' are associated, in the minds of mental health professionals, with challenges to both their position as independent purveyors of care and their attendant perceptions of patients' needs, there may be a reluctance to co-operate with lawyers under any circumstances. As I have pointed out elsewhere (Gordon,1981), in an evaluation of the Mental Patients' Advocate Project in British Columbia, researchers found that where problems existed for the legal service they were rooted in, inter alia, the adversarial nature of the legal service's delivery style. "While the hospital staff did apparently see many advantages to the project and shared many of its objectives, they also voiced a concern about the intrusion of "unnecessary legalism" into the therapeutic setting and its potentially disruptive effect on the therapeutic relationship".[16] This type of finding, which is generally reflected in other, similar studies (see, e.g. Bolton, et al, 1975; Institute of Criminology,1978; Kopolow & Bloom,1977) suggests that the potential for a non-conflictual relationship exists and is probably widespread. Unfortunately the actual establishment of the relationship may be a Promethean task.

As I have argued, the issue of patient power in the therapeutic relationship seems to be the principal problem. That is, providing the power for patients to assert and have recognised, their perception of their own needs; to have a say in determining what is in their 'best interests'. Rights are sought to secure such power although where there is no threat to a patients' status (i.e. a patient is ascribed rather than prescribed, power) there is perhaps no corresponding need for legislatively enshrined rights. In such circumstances there may be no areas of significant conflict between lawyers, patients and mental health staff. In short, if patients' rights and therefore patient power, were simply acknowledged as 'givens' in a treatment setting, legal services might be in a position to assume a different role. In the context of the evolution of legal services for patients, a 'designed' or 'engineered' synthesis might be encouraged to emerge from the current antithetical situation.

To some extent legal services that adopt a non-adversarial approach to answering the legal needs of patients have existed and do exist.[17] However, in such cases the services have tended to deal with the issue of conflicts with mental health staff by simply avoiding the handling of matters pertaining to the institution. As such these organisations may be guilty of simply begging the central question and may do little to tackle the pressing issue of patient power. As a consequence, their contribution may be limited and their position in the evolutionary process reduced to that of a 'mutation'. At the same time, however, they also illustrate a situation that can be created, particularly where a close relationship has been established between legal service and mental health staff in a treatment context. As Monahan has noted (1975), this involves an interdisciplinary approach to mental health care that can have extraordinary benefits for patients and which has long been seen by the proponents of 'orthopsychiatry' as an essential development for an effective mental health system (Levitt & Rubenstein,1968). However, such an approach, it is argued, may be less beneficial where the patient's contribution to health care decision-making is discounted by well-meaning professionals whether they be lawyers or psychiatrists.

In this sense a 'patient welfare' approach, currently regarded by many lawyers as unsatisfactory,[18] may take on a different colour where equity is first established in the relationship between patient and mental health staff. Indeed, such a development simply reflects the growing 'social work' element in the practice of legal aid/poverty law as it is increasingly recognised that purely legal solutions to problems are not completely appropriate in serving clients' needs (Bothmann & Gordon,1979). As I have argued, however, this evolution has, first, required some considerable work by aggressive, partisan advocates who have sought, formally and informally, to establish client power in a variety of relevant situations.

The evolution of the 'patient welfare' approach is also assisted by the increasing emergence of community treatment settings as alternatives to institutionalisation, particularly where such settings involve a a multi-disciplinary approach to health care that incorporates the concept of the 'treatment' or 'therapeutic' team (Lamb,1979; Mental Health Planning Survey,1979). As Talbott notes (1978), such teams are designed "...to encourage working together to maximise the information, skills, and therapeutic leverage..." of different health care professionals (op cit:115). In theory "...they practise the dictum 'two heads are better than one'..."(op cit) and, as Weihoffen has noted (1969), there is every good reason to include a legal aid/poverty law practitioner on such a team. This is particularly the case where social problems with a legal solution may have a significant impact on therapy.[19]

This is not to suggest that such treatment teams are free of problems. As Talbott(1978) and others (Gomez, et al,1980; Bickford,1974; Grieff & McDonald,1973; Birger, et al, 1974; Birjandi & Sclafani,1973; Shapiro & Gudeman,1974; Dean, et al,1976) have noted, the use of the term 'team' does not automatically assume better patient care. Teams cannot be leaderless and, therefore, an element of inequality is present. Professional groups form coalitions to force decisions. Over-discussion may leave little time for therapy and there are noticeable conflicts between psychiatrists and other professionals (Talbott,1978). In addition, as far as can be seen from the relevant literature (Ibid), such teams do not appear to recognise the legitimacy of patients' contributions. The latter seem to be effectively excluded from team meetings and treatment decision-making. In general, the presence of a lawyer as 'neutral', non-mental health professional may be useful in that he or she could act as 'chairperson' or 'team-leader' and thereby act to dispel conflict. This, however, could lead to the suggestion that rather than remaining as informal discussions between colleagues, team meetings would assume the appearance of 'courts'. Such a situation would be totally inappropriate.

More importantly, as Weihoffen argues (1969), the lawyer has a role as an additional resource contributing to the total 'care package' offered to patients. By bringing his or her expertise in poverty law to the treatment team, the lawyer provides access to a resource that is likely to provide patients/clients and other team members with both power in relationships with relevant government agencies and when dealing with less monolithic 'opponents'. Outside of situations involving direct conflict, such lawyers may also be able to negotiate suitable solutions to problems. This contribution may be essential where the tension and anxiety that may be created by adversarial processes is likely to be detrimental to the goals sought by therapy (Bothmann & Gordon,1979). As Meltzer & Schrag argue (1973), the process of negotiation can be a vital aspect of legal aid/poverty law delivery. Confrontation is not always necessary, possible or effective.

To some extent, this type of facility is already being utilised as social workers in community health centres and mental health institutions come to see legal services as an essential community resource for handling clients' problems. Systematic referrals are already being made where legal services are available (Grace & Wilkinson,1978; Bothmann & Gordon,1979; Brieland & Lemmon,1977). As such, the inclusion of a lawyer as a regular feature of any treatment team is merely a process of improving and intensifying an existing relationship that has been recognised as having benefits for mental health and legal service staff, and for patients/clients (op cit).

As Hancock (1980) and Svarez, et al,(1978) have noted, mental health professionals can assist lawyers in a number of ways, particularly where the 'legal' problems they are presented with (e.g. divorce proceedings) embody emotional strain and considerable upheaval in a client's life. In this sense mental health professionals can be an aid to legal services (and ultimately to clients) in the same way that legal service practitioners can assist mental health professionals (and ultimately patients) by joining 'treatment teams', particularly in the community health centre setting. By co-operating, both groups may be doing much to handle effectively the problems confronting patients/clients in the immediate situation. In addition they may also be acting to prevent some mental disorders from arising in the first place.

The notion of 'primary prevention' or 'primary action' is "an idea whose time has come"(Klein & Goldstein, 1977). Although it may have some distance to travel before being established as a crucial and central aspect of mental health care, it can only burgeon on the current wave of enthusiasm for preventing 'pathologies'.[20] Whilst, in the mental health context, it is a development that lacks a consensus in relation to both its precise meaning and the correct method of application (Lamb &

Zusman,1979; Mental Disability Law Reporter,1979), it is clearly one in which legal services, along with other relevant social agencies, have a significant role to play (Hollister,1977; Mental Health Planning Survey,1979; Mental Disability Law Reporter, 1979). This is particularly true where those concerned with primary prevention are extending their mandate to include an involvement in the wider political arena. That is, where they are pointing to the sources of mental and other illnesses that lie in the environment and are seeking to effect reforms that challenge both existing systems for the treatment and 'management' of patients and the social and economic causes of illness (Lamb & Zusman,1979; Lloyd & Stagoll,1979). In such a situation ready access to a lawyer who might be able to engineer relevant litigation could be beneficial.

These developments may, justly, give rise to an air of optimism in relation to the evolution of legal services for patients. However, it is argued that they may not give rise to an effective 'patient welfare' delivery mode until such time as the persistent issue of patient power is resolved. The possible benefits of a 'patient welfare' approach to legal service delivery will remain in suspension so long as this factor is ignored or given only passing consideration. The situation is rendered even more regrettable where examples can be found of treatment settings that are already proceeding in an atmosphere that, a) endorses patient/client involvement in decision-making;

b) accepts the full range of patients' rights as an operational 'given'; and c) generally attempts to offer health care in a context where all perceptions of patients' needs are given a genuine opportunity to an equal hearing in the face of other perceptions of need.

Although many examples of such a setting might be found, one most familiar to this writer exists in Melbourne, Australia. Located in a suburb of the city characterised by a low income/high migrant population (Lloyd & Stagoll,1979; Gordon & Taylor,1979), the Melville Clinic is an experimental community health centre. It is an agency where "staff have equal status in staff discussions" and it has been recognised and praised by patients' organisations because it "grants patients more rights than any other Mental Health Authority institution" (Peoples Health Bulletin,1978b:7). In this latter context, it accepts the full range of such rights as a given, even though such rights are not enshrined in relevant legislation.[21] Further, staff are actively lobbying for improved health care facilities and patients' rights as well as being involved in a number of wider reform-orientated pursuits. Their efforts include encouraging changes to mental health legislation that will attempt to strike an effective balance between health and civil rights needs (Gordon,1980).

Since January 1980, this centre has hosted a regular legal aid 'clinic' staffed by the Fitzroy Legal Service as part of its

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'outreach centres' programme[22] and it is clear that the co-operative atmosphere that has developed is to the ultimate benefit of patients/clients.[23] Health centre staff are able to refer patients/clients to a legal resource with extensive 'back-up' facilities and with expertise in dealing with the types of problems commonly encountered by patients. In turn, legal service staff have access to an 'alternative' mental health treatment setting in cases where patients/clients attending legal 'clinics' throughout the 'catchment area' seek out assistance that can be, in part, provided by health centres.[24]

This situation is recognised by both health centre and legal service staff as an effective way of dealing with patient/client needs. Unfortunately, at this stage, patients/clients have not had an opportunity to express their opinion. However, the possibility of expanding the current arrangements to the point where a legal service practitioner (whether lawyer or para-legal) becomes a permanent member of the centre staff, was welcomed.[25] As patients/clients are apparently given a full opportunity to express their perception of need and as treatment occurs in a non-coercive, non-custodial, setting, it was felt that few difficulties could arise between patients and staff that might create a conflict of interest for a legal service practitioner. There is, after all, a danger that 'co-operation' may turn to 'collusion' where clients seek out a health centre lawyer to handle a disagreement that might arise with mental health staff.

The 'treatment team' approach is, therefore, a viable alternative and is the 'synthesis' that should be 'engineered' in the evolution of patients' legal services in Commonwealth jurisdictions. Although it might take a 'patient welfare' approach to delivery, the latter is not a style that can be equated with the non-adversarial stance displayed by those legal services that have currently adopted the method. In the preferred situation I have outlined, patients' rights (and therefore patient power) in the 'doctor'/patient relationship, is either first established by legislation or recognised as a normative situation, by mental health staff. As such, patients are not placed in a position of subservience and will help determine what should be done to ensure that their 'best interests' are served. The evolution of this approach can only be assisted by developments in psychiatric medicine. Such developments will, probably, at least help to control some of the more adverse symptoms of mental disorders and thereby make community treatment settings a viable alternative for an increasing number of patients. They may also improve the capacity of more patients in <u>any</u> treatment setting to play a central role in determining what is in their 'best interests'.

The growth and impact of this area of legal service delivery holds potential for exciting developments. It is all the more regrettable, therefore, that little (if any) research has been conducted in Commonwealth jurisdictions, in search of answers to attendant problems. For example, any legal service adopting a 'patient welfare' approach would not be in a position to serve the needs of all mental health patients. Despite parallel developments in mental health care that might reduce the need for many patients to enter hospital (Feldman,1975) it is probable that a certain number of patients will continue to be involuntarily committed to insitutions for short periods of time. As many writers have pointed out (Gostin & Rassaby,1980; Institute of Criminology,1978; Kopolow & Bloom,1977) this necessarily brings the hospital into a situation of conflict with a person who may object to hospitalisation. In such cases, referral to a legal service that is part of the institution (e.g. where a lawyer is serving as a member of a 'treatment team') may not be appropriate. In any case, the legal resources offered by such a lawyer would not fall within the area of need that arises in the context of the process of involuntary commitment. In the latter case, what is required is a process whereby the judgements made in relation to the 'best interests' of a patient (and also, perhaps, the community) are subjected to careful scrutiny.

In this respect, access to a partisan advocate may continue to be necessary; that is, access to an <u>independent</u> representative who can test the rationale for the deprivation of a person's liberty. As many writers note, in such circumstances independence on the part of a lawyer is both essential (to avoid any suggestion of 'collusion') and generally expected by patients (Gostin & Rassaby,1980; Green,1979; Kopolow & Bloom,1977). Beyond the specific issues of commitment and continued detention, such a partisan advocate might also play another role. He or she might be the best person to provide the element of 'deterrence' that may be necessary to ensure that the power of the client group is maintained in the broader context of the delivery of legal services. In this respect, a dual role may develop for an agency approximating, for example, the New York Mental Health Information Service (Stone,1975; Page,1973; Kopolow & Bloom,1977).

The operations, function and role of such an organisation have to be carefully examined in the context of Commonwealth jurisdictions. In this respect, a close analysis of the MIND patient representation service may prove fruitful. Similarly the relationship between such an organisation and any legal services adopting a general 'patient welfare' approach must also be explored. To some extent, limited research in this area has begun in Australia (Institute of Criminology, 1978) and Canada (Bolton,<u>et al</u>,1975).[26] However, in general, mental health patients and their needs have not been allocated a high priority and remain largely unexamined. This seems regrettable given that an assessment of the impact of legal services as a resource for answering patients' conventional legal needs could generate both practical and theoretical benefits. For example, it could aid an exploration of the social and environmental causes of some mental illness at the same time offering some practical solutions that would enhance the growth apparently occurring in the provision of community treatment alternatives.

In the context of developments that have already been occurring, little is known about the operations and impact of the different types of legal services in Commonwealth jurisdictions. Similarly, little is known about the effect of legislation that has been devised in an apparent effort to find a compromise between competing perceptions of the health and legal needs of patients. Legislators seem reluctant at the outset to provide for mechanisms that would seek to examine the impact of their work. For example, in relation to Canadian mental health legislation, there are no built-in provisions for reviewing, a) the extent to which an equitable and effective compromise has actually been established; and b) the extent to which any compromise has been applied in practice.

In particular, in the latter case, the operations of review tribunals tend to remain a mystery shrouded in a suspicion that they somehow regularly abrogate basic civil and legal rights. In general, no substantial effort has been made to determine whether the spirit of the legislation is being honoured in the breach. This situation can only serve to raise doubts that, in the pursuit of a compromise, legislators have been concerned more with the interests of the purveyors of mental health care than with the interests of consumers. As Steadman argues (1979b), all this is perhaps a task for the social scientist providing sufficient interest exists and providing the usefulness of any resultant research is realised by the relevant agencies.

If this type of research was undertaken, one might expect a more rapid evolution of legal services for patients that would seek to create an efficient, working atmosphere in the context of mental health care (Feldman,1975). In such a situation, the different professional groups could act "co-operatively instead of antagonistically in meeting patients' wishes, needs and rights" (Kopolow,1977:383). The inconsistencies and confusion of legislation might be exposed in a more thorough fashion than has been attempted in this thesis. In turn, such an exercise might give rise to some further reform that seeks to enhance rather than avoid, the issue of patient 'power'. This could only encourage a more rapid emergence of a 'patient welfare' approach to legal service delivery that takes cognizance of the benefits that could accrue from an expansion of the concept of the 'treatment team'.

As the situation stands at the moment, the need for aggressive, partisan advocates will continue unabated. Whilst the 'best interests' of patients may be served by such advocates the potential for the creation of an alternative situation, free of the dysfunctional aspects of conflict, is not being explored. A persistent question remains unanswered; does this situation exist because the interests of a professional mammon are receiving a higher priority than the interests of consumers? As Stanton has noted (1970), it is often the case that the needs of clients come last.

NOTES

1: This particular issue deserves a separate treatment - particularly as it involves the extent to which unmet legal need is effectively answered by existing legal aid systems and their attendant policies.

The question of 'eligibility' addresses the extent to which 'means tests' and other measures of an individual's ability to meet the cost of legal services, are realistic. Although 'free' legal assistance may be made available to a community, eligibility policies may act to restrain the extent to which individuals can actually avail themselves of the services. Where eligibility criteria are unrealistic a substantial amount of unmet legal need may exist. As I indicated in Chapter 3, voluntary or other independent, legal services often fill the gap between those who are financially eligible for aid and those who are unable to pay but are nevertheless excluded from obtaining legal aid.

The question of 'coverage' addresses the extent to which legal aid policies in a jurisdiction allow for assistance to be provided in a full range of cases. In Canada, for example, legal aid is available, in all jurisdictions, in most criminal law situations. However, in some places, individuals who face problems that arise in a civil law context may not be able to obtain aid. For example, in New Brunswick and Prince Edward Island, legal aid is not made available to those pursuing any matters that fall within the civil jurisdiction (see Chapter 3). It should be noted that these are both provinces where patients' rights in the review tribunal context (the civil jurisdiction) have been consistently enshrined in legislation (see Chapter 5). The latter gives the appearance that the interests of patients are properly protected. However, given that <u>no</u> free or otherwise subsidised, legal aid is available such rights are denied to those who cannot aford the services of a lawyer. This type of situation serves to offer another dimension to the possibility that the entrenching of patients' rights is a hollow gesture of the part of legislators.

In addition to eligibility and coverage policies, it is necessary to consider the extent to which services offered by legal aid systems are accessible to clients. With the evolution of the legal aid movement, substantial debate has ensued in relation to the extent to which conventional delivery settings alienate potential clients (see, e.g., Bothmann & Gordon,1979). In general, two broad questions are raised: i) to what extent are clients <u>physically</u> able to access available legal services; and ii) to what extent are clients <u>psychologically</u> able to access such facilities? Thus, even where eligibility and coverage criteria are found to be 'adequate', it is also necessary to question the extent to which clients can obtain access to available services.

A full examination of these three main issues (eligibility, coverage and accessibility) in conjunction with the issue of patients' rights (especially in the context of review tribunals) would provide a more complex, but fruitful, discussion of the extent to which the legal needs of mental health patients are actually being met.

For a full discussion of eligibility and coverage criteria in Canada see, Auger & Lafond,1979; Bachynsky,1976; Legal Services Commission of Quebec,1978; National Task Force on the Administration of Justice,1979.

2: See Chapter 4.

3: See Chapter 4.

4: See note 13, *infra*.

5: The problems associated with such a development extend beyond the bounds of psychiatry into the medical profession as a whole. This issue has been extensively examined within the 'sociology of professions'. Clearly it is beyond the scope of this thesis to explore the area in depth although it was raised, in the context of professional/client relationships, in Chapter 4. In general this area addresses two main questions.

i) How does occupational status become reified and expanded to assume a wider social significance?

ii) What are the dynamics of the professional/client relationship?

For a full discussion see, in particular, the works of Halmos (*The Personal Service Society*, 1970, Constable, London; *Professionalisation and Social Change*, 1973, University of Keele Press.); Johnson (*Professions and Power*,1972, Macmillan, London.); Jackson (*Professions and Professionalisation*, 1970, Cambridge University Press); McKinlay (*Processing People*, 1975, Hall & Winston, London.); Elliott (*The Sociology of the Professions*, 1976, MacMillan, London.); Friedson (*Professional Dominance*, 1970, Atherton Press, New York; *The Professions and Their Prospects*, 1973, Sage, Beverley Hills); and Larson (*The Rise of Professionalism*, 1977, University of California Press).

6: See, also, Chapter 4.

7: See Chapter 4.

8: For example, government agencies and other groups interacting with low income people may be more inclined to take care to act justly and fairly when handling their affairs. This may arise because of the knowledge that complaints made by such people may be voiced to easily accessible and sympathetic, legal aid lawyers. As a consequence, discomfort may ensue by way of at least considerable agitation if not specific legal action. In short, extensive legal aid facilities may have a considerable deterrent effect. Unfortunately, the extent to which this occurs has not been examined.

9: The extent to which this occurs in the overall legal aid context begs for extensive research.

10: It is possible that, in a dialectic sense, the cycle will begin again after an indeterminable period of time. To some extent this is borne out by the history of developments in mental health systems (see, e.g., Weisstub,1980).

11: See my discussion in Chapter 4.

12: In Commonwealth jurisdictions, this may be a more academic than practical problem for the quest for reform in even perceivably significant and relevant contexts (e.g. administrative review tribunals) has been generally thwarted (see, e.g., Bothmann & Gordon,1979; Zander,1978).

13: The most recent Statistics Canada analysis of the types of patient in Canadian mental health institutions (Statistics Canada,1979(Cat. No. 83-208 Annual)) provides, *inter alia*, a breakdown of the numbers of patients in different diagnostic classes. Out of a total of 50,744 patients, 19,031 were classified as suffering from psychoses; 8,845 from neuroses; 20,791 from mental retardation; and 1,968 from 'other conditions'.

This assists a very basic, broad, and cautious attempt to determine the proportion of patients in hospitals who might be in a position where health needs are paramount. Notwithstanding the obvious deficiencies involved in drawing such inferences, if it can be assumed that all patients classified as psychotic (19,031) and all patients suffering from 'severe' or 'profound' mental retardation (9,091) are those who would fall within a category of 'urgent, extreme or chronic illness', then 28,122 patients (c 55%) may be in a position where their health, rather than civil rights, needs should have priority. This is, in all probability, an extremely generous and crude estimate. For example, simply classifying an individual as psychotic does not necessarily mean that health needs are more important for the person than civil rights needs. However, it does suggest that, given the dominance of psychiatric-centred perceptions of patients' needs, close to at least one half of all patients in mental health institutions may be affected by an unnecessary pre-occupation with their health as opposed to civil rights, needs.

Further support for this possibility comes from a more detailed survey of patients in one major hospital in Canada. The recent British Columbia Mental Health Planning Survey(1979) included an examination of levels of patient care at Riverview Hospital on June 18th 1978 (n = 1077). 50.4% of patients required either continuing psychiatric care involving 24 hour nursing and medical supervision, or intensive observation, supervision or treatment. A further 8.2% required 'pre-infirmary' care involving some psychiatric supervision. Bearing in mind the caveats offered above, it appears that 58.6% of patients might fall into a category where health needs might be a paramount consideration. The remaining 41.4% might be in a different position. It was also felt that 21.3% of patients did not require psychiatric care in the hospital environment, community treatment settings being a better and less restrictive alternative.

14: See, also, my discussion of Bills of Patients' Rights in Chapter 4.

15: It will have been noted from Chapter 3, that a number of different delivery schemes have been attempted, particularly in Canada. The schemes that have persisted have been those that adopt a full or partial, partisan advocacy approach (e.g. The Mental Patients' Advocate Project in British Columbia; the Ontario Legal Aid Plan duty counsel scheme; and the Manitoba Legal Aid duty counsel scheme). The one purely non-adversarial scheme to have been tried (the Ombudsman scheme at Lakeshore Hospital, Toronto) was short-lived. Ombudsmen, both in a provincial and specific hospital context, hold considerable potential as a future source of conflict/dispute resolution in the mental health context (see, e.g., Bolton, et al, 1975; Standing Social Development Committee,1978; Kopolow & Bloom,1977). However, given their role as advisors rather than 'enforcers', their effectiveness is necessarily tied to the extent to which patients' rights or power already exist. As 'power' is, currently, extremely limited it follows that Ombudsmen are, similarly, of only partial use. This may not be true of United States jurisdictions where 'rights' have been extensively established but it does seem to be the case in Commonwealth jurisdictions.

16: Communication with Mr. Alex Himmelfarb and Mr. Avrim Lazar of the Department of Justice, Ottawa, who conducted the evaluation (May 1980).

17 : See Chapter 3.

18: See my discussion in Chapter 4.

19: See my discussion in Chapter 4.

20: Such enthusiasm is clearly affecting a diversity of social and economic institutions. For example, the concept of 'prevention' rather than cure is already firmly established in the practice of medicine and dentistry as a whole. Similarly it is being given impetus in such contexts as criminal justice (e.g. crime prevention through environmental design); industrial environments (e.g. the prevention of accidents); labour relations (e.g. the establishment of contracts and bargaining situations to avoid strikes); and law (e.g. the development of community legal education). As such it can be seen as a development with as much force as the 'consumer movement' but which is perhaps more closely tied to current, global, economic difficulties. In short, it is cheaper to 'prevent' than to 'cure'.

21: Personal conversation with Dr. Brian Stagoll and other staff at Melville Clinic, Brunswick, Melbourne; September 1980.

22: See Chapter 3.

23: See note 21 *supra*.

24 : The legal service has several 'outreach centres' distributed around a portion of the inner city/suburban area of Melbourne. Where problems emerge in one centre and resources are available at another centre suitable referral can be made. The effectiveness of this process, in the mental health context, was experienced by this writer whilst briefly involved in legal service delivery in September 1980. An involuntary mental health patient had 'escaped' from an institution and attended the Fitzroy Legal Service in search of assistance. As her 'affairs' were under the control of the Public Trustee and as she had no friends or relatives to assist her, she had no means of support or aid. She could not be referred to conventional sources of social assistance as this would have meant her 'arrest' and return to the institution. Based on a 'lay' analysis she did not appear to be a danger to herself or others and was temporarily residing with a group of ex-mental patients who were offering some limited shelter. The problem of "what to do" for the client was solved by arranging for her to attend Melville Clinic. As the agency was willing and able to assist the client without insisting on her involuntary return to an institution the issue was effectively and swiftly resolved at the same time acknowledging the primacy of the client's wishes (her perception of what was in her 'best interests').

25: See note 21 <u>supra</u>.

26: See also the evaluation of the Mental Patients' Advocate Project in British Columbia conducted by the Department of Justice, Ottawa. The final report on this project has been prepared but is not yet available for citation.

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